DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 000} | INITIAL COMMENTS<br><br>A revisit was completed at East Tennessee Health Care on March 12, 2012, following acceptance of an Allegation of Compliance to remove the Immediate Jeopardy for F221, F272, F280, F323, F490, F501, and F 520. The revisit revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy but noncompliance continues at F221 "E" level, F280 "E" level, F323 "E" level, F490 "E" level, F501 "E" level, and F520 "E" level, as evidenced by the findings.<br><br>Other deficiencies previously cited and not addressed on the Allegation of Compliance remain outstanding. The facility is required to submit a plan of correction for all outstanding deficiencies including the Immediate Jeopardy deficiencies lowered in severity and scope. | {F 000} | **F 221**<br><br>**483.13(a) Right To Be Free From Physical Restraints**<br><br>**SS=E**<br><br>**Requirements:**<br><br>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. | |
| {F 221} SS=E | 483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS<br><br>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on Guidance for Industry and FDA (Food and Drug Administration March 2006) medical record review, facility policy review, observation, and interview, the facility failed to assess side rails as a restraint, failed to ensure siderails did not pose a risk for entrapment, and failed to reduce or eliminate side rail restraints for six residents (#41, #60, #18, #83, #55, #57) of forty | {F 221} | **Corrective Action Plan:**<br><br>1. As of 3/5/12, the facility is providing a safe environment through the comprehensive assessment of each resident to meet the resident's needs and maintaining their optimal physical, mental and psychosocial well being. The nursing administration staff (Director of Nursing, Staffing Coordinator, and MDS Coordinator) conducted assessments *(assessments-not limited to: Side Rail Assessment* | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 221} | Continued From page 1<br>three residents reviewed.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included:<br><br>Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The facility provided evidence fall risk assessments and side rail assessments were completed for all residents, with removal of side rails when indicated, and evidence bed zone measurements were obtained to reduce or eliminate entrapment risk. The facility provided evidence of in-service for all staff and random audits to ensure compliance.<br><br>The facility will remain out of compliance at a "E" level until it provides an acceptable plan of correction to include continued monitoring to ensure the deficient practice does not recur and the facility's corrective measure could be reviewed and evaluated by the Quality Assurance Committee. | {F 221} | *and Informed Consent (attachment A), Evaluation for the use of Side Rails (attachment B), Pre-Restraint Assessment (attachment C), Physical Restraint Assessment (attachment D), or Fall Risk Assessment (attachment E) completed with date and employee title are referenced by the resident's specific number identifier as follows)* for resident #41, 57, 60, 83, 55, 94 and 18 for the use of side rails/restraints and for current accident prevention interventions.<br>(a) Upon review of the Fall Risk Assessment on 2/6/12 completed by the licensed nurse the systematic review of risk factors indicated a risk score of 24 (high risk) for **resident #41.** Based on the risk factors from his Fall Risk Assessment it was determined that he was not a candidate for the use of side rails due to impaired judgment, incontinence, and history of falls from his bed. The side rails were removed on 2/6/12 by the Maintenance Director. The nursing administration staff communicated changes made to the | |



(2)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 221} | Continued From page 1<br>three residents reviewed.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included:<br><br>Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The facility provided evidence fall risk assessments and side rail assessments were completed for all residents, with removal of side rails when indicated, and evidence bed zone measurements were obtained to reduce or eliminate entrapment risk. The facility provided evidence of in-service for all staff and random audits to ensure compliance.<br><br>The facility will remain out of compliance at a "E" level until it provides an acceptable plan of correction to include continued monitoring to ensure the deficient practice does not recur and the facility's corrective measure could be reviewed and evaluated by the Quality Assurance Committee. | {F 221} | resident's plan of care (removal of side rails and low bed with one mat) to the direct caregivers on the Nurse Aide Communication Worksheet and the Care plans on 2/6/12. On 2/17/12 a telephone order was obtained by the charge nurse and the Director of Nursing to discontinue the resident's bed and chair alarm and use a sensor pressure pad for his bed and chair. The resident remains on a low bed with one mat at bedside after receiving a telephone order from the physician on 2/23/12. The resident's care plan was updated on 2/24/12 by the Interim MDS Coordinator to reflect the current orders and interventions (other interventions: involve in activities, slip resistant footwear, may place in the sight of staff when awake, rest periods as needed, family at bedside sessions throughout the day, get patient up when trying to get out of bed, offer snacks, attempt to keep resident dry or clean immediately after incontinent episode). The care plan was audited by the Nursing Administration Staff to ensure that the plan of care had been updated to reflect the resident's current status on 2/24/12. Resident was hospitalized | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 221} | Continued From page 1<br>three residents reviewed.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included:<br><br>Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The facility provided evidence fall risk assessments and side rail assessments were completed for all residents, with removal of side rails when indicated, and evidence bed zone measurements were obtained to reduce or eliminate entrapment risk. The facility provided evidence of in-service for all staff and random audits to ensure compliance.<br><br>The facility will remain out of compliance at a "E" level until it provides an acceptable plan of correction to include continued monitoring to ensure the deficient practice does not recur and the facility's corrective measure could be reviewed and evaluated by the Quality Assurance Committee. | {F 221} | from 2/24/12 to 3/2/12, returning with a change in medical status. The Fall Risk Assessment updated on 3/5/12 by the Director of Nursing reflects that resident no longer attempts to self transfer, requiring assistance of 2 for transfers. The resident no longer requires constant supervision for the prevention of falls. He is on the Falls Reduced Our Goal, FROG, (attachment G) Program that provides closer observation from various staff members. Resident was transferred to the hospital again on 3/9/12 after visit by attending physician. MDS Coordinator completed a discharge assessment on 3/9/12. Resident was readmitted on 3/15/12 with admitting Charge Nurse completing Fall Risk Assessment and Evaluation for the Use of Side Rails with the recommendation to be that side rails were not indicated at that time. Resident's care plan was updated on 3/21/12 with a significant change assessment. Resident's care plan is updated | |



4

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 221} | Continued From page 1<br>three residents reviewed.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included:<br><br>Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The facility provided evidence fall risk assessments and side rail assessments were completed for all residents, with removal of side rails when indicated, and evidence bed zone measurements were obtained to reduce or eliminate entrapment risk. The facility provided evidence of in-service for all staff and random audits to ensure compliance.<br><br>The facility will remain out of compliance at a "E" level until it provides an acceptable plan of correction to include continued monitoring to ensure the deficient practice does not recur and the facility's corrective measure could be reviewed and evaluated by the Quality Assurance Committee. | {F 221} | per MDS and/or Charge Nurse on ongoing bases and as needed with<br><br>any new orders, interventions, or changes.<br><br>(b) **Resident # 60** The side rails that were in place during the survey were immediately changed to full anti-entrapment rails (prior to the exit of the surveyors) on 2/6/12 by the Maintenance Director. The measurements for the bed zones were obtained by the Maintenance Director on 2/6/12 using a standard tape measure. The Side Rail Assessment and Informed Consent Form (one form) was later completed by the Staffing Coordinator on 2/6/12 for the use of side rails with a reduction from full side rails to ½ side rails after receiving a physician's order for the use of ½ rails by the Staffing Coordinator (after the exit of the surveyors for the evening) that were changed out per the Maintenance Director. The bed | |



5

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 466 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 221} | Continued From page 1<br>three residents reviewed.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included:<br><br>Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The facility provided evidence fall risk assessments and side rail assessments were completed for all residents, with removal of side rails when indicated, and evidence bed zone measurements were obtained to reduce or eliminate entrapment risk. The facility provided evidence of in-service for all staff and random audits to ensure compliance.<br><br>The facility will remain out of compliance at a "E" level until it provides an acceptable plan of correction to include continued monitoring to ensure the deficient practice does not recur and the facility's corrective measure could be reviewed and evaluated by the Quality Assurance Committee. | {F 221} | zone measurements were obtained by the Maintenance Director on 2/6/12. A Pre-Restraint Assessment was completed on 2/21/12 by the Staffing Coordinator that indicated side rails being used as a restraint and assisting the resident with position changes. An Evaluation for the use of Side Rails was completed on 2/23/12 by the Staffing Coordinator with a reduction of side rails from ½ side rails to ¼ side rail in combination with a low bed. The bed/side rails were changed out by the Maintenance Director; measurements were obtained on 2/23/12. The care plan was audited by the Nursing Administration Staff to ensure that the plan of care had been updated to reflect the resident's current status on 2/26/12. Resident was transferred to hospital on 2/26/12. The Interim MDS Coordinator completed a Discharge Assessment on 2/29/12 which reflected the use of side | |



b

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 221} | Continued From page 1<br>three residents reviewed.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included:<br><br>Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The facility provided evidence fall risk assessments and side rail assessments were completed for all residents, with removal of side rails when indicated, and evidence bed zone measurements were obtained to reduce or eliminate entrapment risk. The facility provided evidence of in-service for all staff and random audits to ensure compliance.<br><br>The facility will remain out of compliance at a "E" level until it provides an acceptable plan of correction to include continued monitoring to ensure the deficient practice does not recur and the facility's corrective measure could be reviewed and evaluated by the Quality Assurance Committee. | {F 221} | rails as a restraint (as ½ rails were used until 2/23/12 during the 7 day look back period). The resident was reassessed upon return to the facility on 3/12/12 by the admitting Charge Nurse who completed an Evaluation for the use of Side Rails and a Fall Risk Assessment with the recommendation for no side rails indicated at this time. The MDS Coordinator completed a 5 day Readmission Assessment on 3/22/12. (A 14 day Assessment was completed on 3/29/12). Resident's care plan is updated per MDS and/or Charge Nurse on an ongoing base and as needed with any new orders, interventions, or changes.<br><br>(c) **Resident #18** The side rails that were in place during the survey were immediately changed to full anti-entrapment rails on 2/6/12 by the Maintenance Director after receiving a | |



7

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 221} | Continued From page 1<br>three residents reviewed.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included:<br><br>Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The facility provided evidence fall risk assessments and side rail assessments were completed for all residents, with removal of side rails when indicated, and evidence bed zone measurements were obtained to reduce or eliminate entrapment risk. The facility provided evidence of in-service for all staff and random audits to ensure compliance.<br><br>The facility will remain out of compliance at a "E" level until it provides an acceptable plan of correction to include continued monitoring to ensure the deficient practice does not recur and the facility's corrective measure could be reviewed and evaluated by the Quality Assurance Committee. | {F 221} | physician's order. The measurements for the bed zones were obtained by the Maintenance Director on 2/6/12 using a standard tape measure with measurements. The Staffing Coordinator wrote a narrative note in the nurses notes on 2/6/12 describing the resident with limited functional status using the side rails as a restraint. A Physical Restraint Assessment was updated on 2/6/12 by the Staffing Coordinator for the use of side rails. A Side Rail Assessment and Informed Consent was signed by the family on 2/13/12. On 2/20/12 the MDS Coordinator completed an Evaluation for use of Side Rails with a reduction in side rails from full (anti-entrapment) to ½ rails, the physician was notified and order was obtained for ½ rails. The measurements for the bed zones were obtained by the Maintenance Director on 2/20/12. On 2/23/12 the resident was evaluated again for side rail reduction by the | |



8

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 221} | Continued From page 1<br>three residents reviewed.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included:<br><br>Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The facility provided evidence fall risk assessments and side rail assessments were completed for all residents, with removal of side rails when indicated, and evidence bed zone measurements were obtained to reduce or eliminate entrapment risk. The facility provided evidence of in-service for all staff and random audits to ensure compliance.<br><br>The facility will remain out of compliance at a "E" level until it provides an acceptable plan of correction to include continued monitoring to ensure the deficient practice does not recur and the facility's corrective measure could be reviewed and evaluated by the Quality Assurance Committee. | {F 221} | Staffing Coordinator, the resident's side rails was eliminated and the resident was placed on a low bed with mats. The Physical Restraint Assessment was completed on 2/28/12 by the Staffing Coordinator for the elimination of side rails and the use of a low bed with mats after receiving a physician's order. The care plan was audited by the Nursing Administration Staff to ensure that the plan of care had been updated to reflect the resident's current status on 2/29/12. On 3/5/12 resident rolled out of bed with a small laceration to upper lip with intervention to check placement of furniture and remove if in pathway. Keep room free of clutter for safety, Bowel and bladder program to determine habit time, and Falls Reduced Our Goal. FROG Program. Care plan was updated to reflect new interventions for 3/5. 3/13 resident was found in room 129 bathroom with one shoe on. | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 221} | Continued From page 1<br>three residents reviewed.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included:<br><br>Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The facility provided evidence fall risk assessments and side rail assessments were completed for all residents, with removal of side rails when indicated, and evidence bed zone measurements were obtained to reduce or eliminate entrapment risk. The facility provided evidence of in-service for all staff and random audits to ensure compliance.<br><br>The facility will remain out of compliance at a "E" level until it provides an acceptable plan of correction to include continued monitoring to ensure the deficient practice does not recur and the facility's corrective measure could be reviewed and evaluated by the Quality Assurance Committee. | {F 221} | Resident had gotten up from her wheel chair in another resident's room, with interventions for proper footwear (nonskid) replace footwear when resident removes as allows with physical therapy to screen. On 3/15, further intervention was added to get up after breakfast as desires after further investigation of fall on 3/13. Fall on 3/17 where resident rolled from the bed in her sleep, bed was in lowest position with mats on both sides, no injury noted, intervention to add pool noodles to define perimeter of the bed with all above interventions added to the care plan as implemented. Resident's care plan is updated per MDS and/or Charge Nurse on an ongoing<br><br>bases and as needed with any new orders, interventions, or changes.<br><br>(d) **Resident #83** *The recapitalization orders were signed by the physician for 2/2/12 included an order for the use of side rails.* An assessment was | |



10

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 221} | Continued From page 1<br>three residents reviewed.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included:<br><br>Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The facility provided evidence fall risk assessments and side rail assessments were completed for all residents, with removal of side rails when indicated, and evidence bed zone measurements were obtained to reduce or eliminate entrapment risk. The facility provided evidence of in-service for all staff and random audits to ensure compliance.<br><br>The facility will remain out of compliance at a "E" level until it provides an acceptable plan of correction to include continued monitoring to ensure the deficient practice does not recur and the facility's corrective measure could be reviewed and evaluated by the Quality Assurance Committee. | {F 221} | completed on 2/6/12 using a Pre-Restraint Assessment for the use of ¾ side rails completed by the MDS Coordinator indicating a restraint was recommended related to cognitive impairment, requiring physical assistance, and unaware of safety issues. On 2/20/12 an Evaluation for the use of Side Rail Assessment was completed by the MDS Coordinator indicating the resident was unaware of safety needs, cognitive impairment, and requiring physical assistance utilizing ¾ side rails. A new Evaluation for the use of Side Rails was completed on 2/23/12 by the Director of Nursing for the reduction of side rails from ¾ to ½. The resident's Physical Restraint Assessment was updated on 2/23/12 by the Director of Nursing for the restraint reduction *and* new orders received for the use of ½ side rails. On 2/28/12, an Evaluation for the use of Side Rails and Physical Restraint Assessment | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 466 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 221} | Continued From page 1<br>three residents reviewed.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included:<br><br>Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The facility provided evidence fall risk assessments and side rail assessments were completed for all residents, with removal of side rails when indicated, and evidence bed zone measurements were obtained to reduce or eliminate entrapment risk. The facility provided evidence of in-service for all staff and random audits to ensure compliance.<br><br>The facility will remain out of compliance at a "E" level until it provides an acceptable plan of correction to include continued monitoring to ensure the deficient practice does not recur and the facility's corrective measure could be reviewed and evaluated by the Quality Assurance Committee. | {F 221} | was completed by the Director of Nursing indicating the elimination of ½ rails and placed on low bed with mats. The care plan was audited by the Nursing Administration Staff to ensure that the plan of care had been updated to reflect the resident's current status on 2/29/12. Care plan is current to resident's status and is updated per MDS and/or Charge Nurse on an ongoing bases and as needed with any new orders, interventions, or changes.<br><br>(e) **Resident # 55** was assessed using a Pre-Restraint Assessment (used due to the use of side rails as restraint) was completed on 2/6/12 by the MDS Coordinator indicating that a restraint (3/4 side rail and geri chair) was recommended due to cognition impaired, physical limitations, and history of falls. The care plan was audited by the Nursing Administration Staff to ensure that the plan of care had been updated to reflect the resident's current status on 2/6/12. No further assessments could be completed due to the resident expiring on 2/16/12. | |



12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 221} | Continued From page 1<br>three residents reviewed.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included:<br><br>Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The facility provided evidence fall risk assessments and side rail assessments were completed for all residents, with removal of side rails when indicated, and evidence bed zone measurements were obtained to reduce or eliminate entrapment risk. The facility provided evidence of in-service for all staff and random audits to ensure compliance.<br><br>The facility will remain out of compliance at a "E" level until it provides an acceptable plan of correction to include continued monitoring to ensure the deficient practice does not recur and the facility's corrective measure could be reviewed and evaluated by the Quality Assurance Committee. | {F 221} | (f) **Resident # 57** A telephone order was received from the resident's physician for the use of ½ side rails on 2/10/12. The resident was assessed on 2/20/12 using the Evaluation for use of Side Rails (for the evaluation of side rail use) indicating the use of ½ side rails by the Staffing Coordinator. A Pre-Restraint Assessment was completed on 2/21/12 by the Director of Nursing that indicated side rails are used as a restraint. On 2/24/12 another Evaluation for the use of Side Rail was completed by the Staffing Coordinator indicating the elimination of ½ side rails (no side rails are in place at this time). As of 2/24/12 the resident's interventions include: the locking of wheel chair prior to transfer, offer rest periods, assist to the bathroom during rounds and as needed, bed in lowest position, a chair sensor pad. The care plan was audited by the Nursing Administration Staff to ensure that the plan of care had been updated to reflect the resident's current status on 2/29/12. The resident's care plan was reviewed by the Director of Nursing on 3/7/12 and evaluated for fall prevention strategies and deemed | |



13

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 466 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 221} | Continued From page 1<br>three residents reviewed.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included:<br><br>Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The facility provided evidence fall risk assessments and side rail assessments were completed for all residents, with removal of side rails when indicated, and evidence bed zone measurements were obtained to reduce or eliminate entrapment risk. The facility provided evidence of in-service for all staff and random audits to ensure compliance.<br><br>The facility will remain out of compliance at a "E" level until it provides an acceptable plan of correction to include continued monitoring to ensure the deficient practice does not recur and the facility's corrective measure could be reviewed and evaluated by the Quality Assurance Committee. | {F 221} | the intervention for constant supervision during toileting was inappropriate. After review of current interventions on 3/7/12 by the Director of Nursing and further investigation of the incident (with intervention not to leave unattended) it was determined that the intervention was implemented before a full root cause analysis was conducted (the intervention was removed as of 2/24/12 interventions above). As of 3/22/12, current interventions, the resident remains on the FROG (Falls Reduced Our Goal) program, participates in restorative with ambulation "walk to dine program", low bed with mats, antiroll back brakes, the locking of wheel chair prior to transfer, offer rest periods, ask resident frequently on rounds if she would like anything or needs assist to the bathroom during rounds and as needed, further monitoring and interventions will continue to prevent falls. Resident's care plan is current and updated per MDS and/or Charge Nurse on an ongoing bases and as needed with any new orders, interventions, or changes. | |

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 221} | Continued From page 1<br>three residents reviewed.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included:<br><br>Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The facility provided evidence fall risk assessments and side rail assessments were completed for all residents, with removal of side rails when indicated, and evidence bed zone measurements were obtained to reduce or eliminate entrapment risk. The facility provided evidence of in-service for all staff and random audits to ensure compliance.<br><br>The facility will remain out of compliance at a "E" level until it provides an acceptable plan of correction to include continued monitoring to ensure the deficient practice does not recur and the facility's corrective measure could be reviewed and evaluated by the Quality Assurance Committee. | {F 221} | 2. (a) The Nursing Administration Staff(Director of Nursing, MDS Coordinator, and Staffing Coordinator) reviewed all residents using side rails, assessing and coding the resident's assessment correctly. Residents using side rails as a restraint were identified and care planned accordingly. A comprehensive assessment was completed; interventions were modified as needed and placed on the individuals care plan. The Administration Team (Administrator, Director of Nursing, and Assistant Director of Nursing, Maintenance Supervisor, Social Services/Admissions Director, MDS Coordinator, Food Service Supervisor, Activity Director, and/or Medical Director) developed a Side Rail Policy with the involvement of the Medical Director with implementation on 2/28/12 to include the utilization of the Evaluation for the use of Side Rail Assessment.<br><br>**(b)** A total of 65 residents were identified on 2/6/12 as having side rails attached to their bed | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 466 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 221} | Continued From page 1<br>three residents reviewed.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included:<br><br>Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The facility provided evidence fall risk assessments and side rail assessments were completed for all residents, with removal of side rails when indicated, and evidence bed zone measurements were obtained to reduce or eliminate entrapment risk. The facility provided evidence of in-service for all staff and random audits to ensure compliance.<br><br>The facility will remain out of compliance at a "E" level until it provides an acceptable plan of correction to include continued monitoring to ensure the deficient practice does not recur and the facility's corrective measure could be reviewed and evaluated by the Quality Assurance Committee. | {F 221} | frame (ranging from ¼ to full side rails). The nursing administration Team (Director of Nursing, Staffing, Coordinator and MDS Coordinator) assessed residents using side rails utilizing the Evaluation for the use of Side Rails on 2/28/12 and 2/29/12.<br><br>These tools (Side Rail Assessment and Informed Consent Form, Evaluation for the use of Side Rails, Pre-Restraint Assessment, and the Physical Restraint Assessment) were used for the purpose of assessing residents using side rails to determine if side rails were needed and/or could be reduced; notification of family and/or resident of the use of side rails/restraints, to determine if a restraint was recommended, and to review the resident for possible reduction of a restraint. The Pre-Restraint Assessment was completed for residents using side rails as restraints to assess residents using side rails to determine if side rails were | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 221} | Continued From page 1<br>three residents reviewed.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included:<br><br>Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The facility provided evidence fall risk assessments and side rail assessments were completed for all residents, with removal of side rails when indicated, and evidence bed zone measurements were obtained to reduce or eliminate entrapment risk. The facility provided evidence of in-service for all staff and random audits to ensure compliance.<br><br>The facility will remain out of compliance at a "E" level until it provides an acceptable plan of correction to include continued monitoring to ensure the deficient practice does not recur and the facility's corrective measure could be reviewed and evaluated by the Quality Assurance Committee. | {F 221} | recommended as a restraint on 2/28/12 by the Nursing Administration Team, with findings documented on the resident's individual assessment form (Side Rail Assessment and Informed Consent Form, Evaluation for the use of Side Rails, Pre-Restraint Assessment and/or the Physical Restraint Assessment). Through the individual resident assessment and monitoring of side rail use, the facility has been able to reduce the use of side rails with a current total of 4 residents (no full rails). Side rails that were reduced or removed by the Maintenance Director based on the resident's individual assessment results by nurse administration beginning on 2/6/12 through 2/29/12. The Maintenance Director and the Maintenance Assistant obtained measurements of all remaining side rails using a standard tape measure. Measurements were obtained with the bed in a flat and | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 221} | Continued From page 1<br>three residents reviewed.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included:<br><br>Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The facility provided evidence fall risk assessments and side rail assessments were completed for all residents, with removal of side rails when indicated, and evidence bed zone measurements were obtained to reduce or eliminate entrapment risk. The facility provided evidence of in-service for all staff and random audits to ensure compliance.<br><br>The facility will remain out of compliance at a "E" level until it provides an acceptable plan of correction to include continued monitoring to ensure the deficient practice does not recur and the facility's corrective measure could be reviewed and evaluated by the Quality Assurance Committee. | {F 221} | articulated position. All findings met the FDA recommendations as referenced in the FDA Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment. Any side rail that measured outside the FDA recommendations were replaced as needed with anti-entrapment rails, shorter side rails (1/4, ½, and 3/4) or eliminated as needed based on the resident's individual assessments and/or for non-use.<br><br>(c) *The resident's physician,* family member and/or residents were made aware of side rail assessments/restraint findings on 2/6/12, *obtaining new orders as needed* by the Nursing Administration Team, *the family and/or resident provided* verbal consent for the use of side rail/restraint as indicated.<br><br>Ongoing communication will be discussed with families/residents regarding the use of side rails and restraint upon admission and/or as assessment findings change, by the Admission Coordinator, | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 221} | Continued From page 1<br>three residents reviewed.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included:<br><br>Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The facility provided evidence fall risk assessments and side rail assessments were completed for all residents, with removal of side rails when indicated, and evidence bed zone measurements were obtained to reduce or eliminate entrapment risk. The facility provided evidence of in-service for all staff and random audits to ensure compliance.<br><br>The facility will remain out of compliance at a "E" level until it provides an acceptable plan of correction to include continued monitoring to ensure the deficient practice does not recur and the facility's corrective measure could be reviewed and evaluated by the Quality Assurance Committee. | {F 221} | Charge Nurse or Nurse Administration Team.<br><br>3.(a) The nursing administration staff (Director of Nursing, Assistant Director of Nursing, and MDS Coordinator) communicated changes to the resident's status such as bed changes, modification of side rails, or modification to restraint usage to the direct care givers (list not all inclusive: CNA's , licensed nurses, and therapist) on the Nurse Aide Communication Worksheet, Care Plans, and/or the 24 hour report book as of 2/28/12. The Assistant Director of Nursing or the MDS Coordinator will post an updated list for residents with side rails in the front of the CNA assignment book as changes are made to the resident's current side rail status beginning 2/29/12. The MDS Coordinator, the backup MDS Coordinator, and/or charge nurse will update the care plan, and the Nurse Aide Communication Sheet to reflect changes as new orders or events occur, communicating changes via the 24 hour report. | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 221} | Continued From page 1<br>three residents reviewed.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included:<br><br>Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The facility provided evidence fall risk assessments and side rail assessments were completed for all residents, with removal of side rails when indicated, and evidence bed zone measurements were obtained to reduce or eliminate entrapment risk. The facility provided evidence of in-service for all staff and random audits to ensure compliance.<br><br>The facility will remain out of compliance at a "E" level until it provides an acceptable plan of correction to include continued monitoring to ensure the deficient practice does not recur and the facility's corrective measure could be reviewed and evaluated by the Quality Assurance Committee. | {F 221} | (b) The Maintenance Director or Assistant will bring the Side Rail Log to the morning Quality Assurance meeting to discuss any findings related to side rail measurements. The Side Rail log will be used to record the findings of side rail measurements (when a side rail is added, quarterly, and/or as needed).<br><br>(c) Measurements obtained by the Maintenance Director, Assistant, or charge nurse, as recommended in the Food and Drug Administration (FDA) Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment dated March 10, 2006. The Side Rail Log (attachment H) process is part of the new Side Rail Policy initiated 2/28/12. All staff was in serviced by the Administrator, Maintenance Director and/or the Director of Nursing regarding but not limited to: the completion of Side Rail Assessment and Informed Consent, Evaluation for the use of Side Rails to be | |



20

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 221} | Continued From page 1<br>three residents reviewed.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included:<br><br>Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The facility provided evidence fall risk assessments and side rail assessments were completed for all residents, with removal of side rails when indicated, and evidence bed zone measurements were obtained to reduce or eliminate entrapment risk. The facility provided evidence of in-service for all staff and random audits to ensure compliance.<br><br>The facility will remain out of compliance at a "E" level until it provides an acceptable plan of correction to include continued monitoring to ensure the deficient practice does not recur and the facility's corrective measure could be reviewed and evaluated by the Quality Assurance Committee. | {F 221} | completed prior to the use of side rails, Pre-Restraint Assessment, Physical Restraint Assessment (when, on whom, why, and how the assessment is to be completed), the risk of entrapment associated with side rail use and how to obtain bed zone measurements per the FDA "best practice" standards on 2/29/12. All staff including new hires, contracted staff (performing direct care) and staff on leave of absence will be in serviced by the Administrator, Maintenance Director and/or the Director of Nursing regarding but not limited to: the completion of Side Rail Assessment and Informed Consent, Evaluation for the use of Side Rails to be completed prior to the use of side rails, Pre-Restraint Assessment, Physical Restraint Assessment (when, on whom, why, and how the assessment is to be completed), the risk of entrapment associated with side rail use and how to | |



21

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 221} | Continued From page 1<br>three residents reviewed.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included:<br><br>Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The facility provided evidence fall risk assessments and side rail assessments were completed for all residents, with removal of side rails when indicated, and evidence bed zone measurements were obtained to reduce or eliminate entrapment risk. The facility provided evidence of in-service for all staff and random audits to ensure compliance.<br><br>The facility will remain out of compliance at a "E" level until it provides an acceptable plan of correction to include continued monitoring to ensure the deficient practice does not recur and the facility's corrective measure could be reviewed and evaluated by the Quality Assurance Committee. | {F 221} | obtain bed zone measurements per the FDA "best practice" standards prior to working their scheduled shift.<br><br>(d) Facility staff was in-serviced on 2/6/12, 2/7/12, 2/8/12, 2/9/12, 2/13/12, 2/17/12, and/or 2/24/12 by the Administrator, Maintenance Director and/or the Director of Nursing regarding but not limited to: the completion of Side Rail Assessment and Informed Consent, Evaluation for the use of Side Rails to be completed prior to the use of side rails, Pre-Restraint Assessment, Physical Restraint Assessment (when, on whom, why, and how the assessment is to be completed), the risk of entrapment associated with side rail use and how to obtain bed zone measurements per the FDA "best practice" standards and again on 2/29/12. Another in-service was presented by the Administrator on 3/15/12 to review survey findings and the plan of correction. | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 466 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 221} | Continued From page 1<br>three residents reviewed.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included:<br><br>Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The facility provided evidence fall risk assessments and side rail assessments were completed for all residents, with removal of side rails when indicated, and evidence bed zone measurements were obtained to reduce or eliminate entrapment risk. The facility provided evidence of in-service for all staff and random audits to ensure compliance.<br><br>The facility will remain out of compliance at a "E" level until it provides an acceptable plan of correction to include continued monitoring to ensure the deficient practice does not recur and the facility's corrective measure could be reviewed and evaluated by the Quality Assurance Committee. | {F 221} | (e) The Administrator contacted the Q-Source representative who registered the Director of Nursing, Assistant Director of Nursing, Activity Director and MDS Coordinator for a ***Physical Restraint & Pressure Ulcer Regional Collaborative Learning Session*** on April10, 2012.<br><br>(t) Upon admission/readmission, residents will be assessed using the Evaluation for the use of Side Rail Assessment tool by the Charge Nurse or Nursing Administration for the appropriateness of side rails (using the least restrictive device). Further side rail evaluations will be reviewed with significant changes, at a minimum of quarterly and/or as needed by the charge nurse, MDS Coordinator and/or nursing administration. The least restrictive side rail will be used as a restraint only after all other alternatives (list not all inclusive: low bed with mats, bed in lowest position, pool noodles, wing mattresses, toileting schedules, activities, non-skid surfaces, modification of room location, observe behavior/wake patterns, assistive devices, reclining /rocker | |



23

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 466 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 221} | Continued From page 1<br>three residents reviewed.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included:<br><br>Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The facility provided evidence fall risk assessments and side rail assessments were completed for all residents, with removal of side rails when indicated, and evidence bed zone measurements were obtained to reduce or eliminate entrapment risk. The facility provided evidence of in-service for all staff and random audits to ensure compliance.<br><br>The facility will remain out of compliance at a "E" level until it provides an acceptable plan of correction to include continued monitoring to ensure the deficient practice does not recur and the facility's corrective measure could be reviewed and evaluated by the Quality Assurance Committee. | {F 221} | chairs, drop seats, tilt back chairs, family visits) have been attempted without success. A Pre-Restraint Assessment will be completed by the charge nurse or by a member of the Nursing Administration Staff prior to the use of a restraint. The Pre-Restraint Assessment will guide the nurse in making a decision if a restraint is recommended and/or offer alternative ideas (on the back of form) that may reduce the risk of injuries associated with falls/restraints for those residents at high risk for falls without the use of a physical device. An alternative intervention can be attempted based on the individual resident's Pre-Restraint Assessment in no specific order. The Pre-Restraint Assessment can be updated on an ongoing basis for interventions that have been attempted without success with the date written to the side of the intervention attempted. If a restraint is recommended, the resident will be assessed at a minimum of quarterly and/or as needed to determine if the restraint remains an appropriate intervention or if a reduction can be attempted. After the completion of an | |



24

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 221} | Continued From page 1<br>three residents reviewed.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included:<br><br>Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The facility provided evidence fall risk assessments and side rail assessments were completed for all residents, with removal of side rails when indicated, and evidence bed zone measurements were obtained to reduce or eliminate entrapment risk. The facility provided evidence of in-service for all staff and random audits to ensure compliance.<br><br>The facility will remain out of compliance at a "E" level until it provides an acceptable plan of correction to include continued monitoring to ensure the deficient practice does not recur and the facility's corrective measure could be reviewed and evaluated by the Quality Assurance Committee. | {F 221} | Evaluation for the use of Side Rail assessment and/or a Pre-Restraint Assessment, the Maintenance Director or Maintenance Assistant will be notified by the nurse of the least restrictive side rails needed to achieve the resident's highest physical functioning status. The Maintenance Director or Assistant will place the appropriate side rails on the resident's bed measuring each Zone using a standard tape measure, documenting his findings on the Side Rail Log. The Maintenance Director demonstrated the bed zone measuring process to each Charge Nurse and a return demonstration was performed by each charge nurse (2/7/12 – 3/1/12). If a resident's condition changes that may require a change in the side rail type, the nurse must first complete a new Evaluation for the use of Side Rail Assessment, notify the physician to obtain new orders, then notify the Maintenance Director and/or Assistant for placement. Side rails will be measured each time there is a change in the side rail type, quarterly, and as needed by the Maintenance Director or Assistant. | |



25

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 221} | Continued From page 1<br>three residents reviewed.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included:<br><br>Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The facility provided evidence fall risk assessments and side rail assessments were completed for all residents, with removal of side rails when indicated, and evidence bed zone measurements were obtained to reduce or eliminate entrapment risk. The facility provided evidence of in-service for all staff and random audits to ensure compliance.<br><br>The facility will remain out of compliance at a "E" level until it provides an acceptable plan of correction to include continued monitoring to ensure the deficient practice does not recur and the facility's corrective measure could be reviewed and evaluated by the Quality Assurance Committee. | {F 221} | (g) The Regional Nurse Consultant in-serviced the MDS Coordinator and the Staffing Coordinator/Back Up MDS Coordinator on 2/21/12 and 2/22/12 on the completion of accurate assessments and developing/revision of care plans to reflect the resident's current medical condition. The MDS Coordinator will obtain a physician's order, initiate a Pre-Restraint Assessment, complete an Evaluation for the Use of Side Rails, and obtain a Side Rail Assessment and Informed Consent form for newly coded side rails on the MDS, along with revising the resident's care plan. If the side rail is a continuation from the resident's previous assessment, a Physical Restraint Assessment will be reviewed and updated to determine if the resident is a candidate for restraint reduction. The Interdisciplinary Team (not limited to: Director/Assistant Director of Nursing, MDS Coordinator, | |



26

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 221} | Continued From page 1<br>three residents reviewed.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included:<br><br>Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The facility provided evidence fall risk assessments and side rail assessments were completed for all residents, with removal of side rails when indicated, and evidence bed zone measurements were obtained to reduce or eliminate entrapment risk. The facility provided evidence of in-service for all staff and random audits to ensure compliance.<br><br>The facility will remain out of compliance at a "E" level until it provides an acceptable plan of correction to include continued monitoring to ensure the deficient practice does not recur and the facility's corrective measure could be reviewed and evaluated by the Quality Assurance Committee. | {F 221} | Social Services, Activity Director) will also discuss residents with restraints monthly in their Fall Focus Meeting for modification and/or reduction. Resident and families will be notified of scheduled care plan meetings by the MDS Coordinator prior to the residents next scheduled assessment and/or as needed to assist in developing a plan of care that meets the resident's personal/medical goals. The MDS Coordinator will utilize information provided in the morning QA meeting, 24 hour report, resident's medical record, and communication from staff, residents, and/or families when completing resident assessments to ensure accuracy. On 2/23/12 the Interim MDS Coordinator was in-serviced by the Regional Nurse Consultant on accuracy when completing MDS's and the development and revision of care plans, along with recent survey deficiencies. On 3/5/12 the Regional Nurse Consultant in- | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 221} | Continued From page 1<br>three residents reviewed.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included:<br><br>Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The facility provided evidence fall risk assessments and side rail assessments were completed for all residents, with removal of side rails when indicated, and evidence bed zone measurements were obtained to reduce or eliminate entrapment risk. The facility provided evidence of in-service for all staff and random audits to ensure compliance.<br><br>The facility will remain out of compliance at a "E" level until it provides an acceptable plan of correction to include continued monitoring to ensure the deficient practice does not recur and the facility's corrective measure could be reviewed and evaluated by the Quality Assurance Committee. | {F 221} | serviced the MDS Coordinator on documenting (communication) changes made to the resident's plan of care on the 24 hour report.<br><br>(h) The Regional Director of Operations in-serviced the Administrator, the Maintenance Director and the Maintenance Assistant regarding the FDA Safety Alert: Entrapment Hazards with Hospital Bed Side Rails and shared by the surveyors during facility demonstration of measuring bed zones (included flat and articulated positions) on 2/7/12. The Maintenance Director and the Maintenance Assistant were able to demonstrate competency through a return demonstration on 2/7/12 on measuring the bed zones in flat and articulated positions (related to the information provided during the survey). The Regional Director of Operations also in-serviced the Maintenance Director and Assistant on 2/13/12 regarding The FDA Hospital Bed System Dimensional and | |



28

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 221} | Continued From page 1<br>three residents reviewed.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included:<br><br>Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The facility provided evidence fall risk assessments and side rail assessments were completed for all residents, with removal of side rails when indicated, and evidence bed zone measurements were obtained to reduce or eliminate entrapment risk. The facility provided evidence of in-service for all staff and random audits to ensure compliance.<br><br>The facility will remain out of compliance at a "E" level until it provides an acceptable plan of correction to include continued monitoring to ensure the deficient practice does not recur and the facility's corrective measure could be reviewed and evaluated by the Quality Assurance Committee. | {F 221} | Assessment Guidance to Reduce Entrapment dated March 10, 2006.<br><br>4. (a) The Administrator or Director of Nursing will review the Side Rail Log daily (Monday-Friday) to ensure the document is completed as needed to reflect the resident's current side rail measurements for the next 90 days; then weekly for 90 days if compliance has been maintained; then randomly thereafter. If at any point compliance is not met, the party will resume monitoring daily (Monday-Friday) until compliance is maintained.<br><br>(b)The Director of Nursing, Assistant Director of Nursing, or RN Weekend Supervisor will conduct daily audits for 90 days through facility walking rounds, review of the 24 hour report, care plans, Nurse Aide Communication Sheets, Evaluation for the Use of Side Rails, and Nurse Event notes to ensure the appropriate procedures | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 466 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 221} | Continued From page 1<br>three residents reviewed.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included:<br><br>Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The facility provided evidence fall risk assessments and side rail assessments were completed for all residents, with removal of side rails when indicated, and evidence bed zone measurements were obtained to reduce or eliminate entrapment risk. The facility provided evidence of in-service for all staff and random audits to ensure compliance.<br><br>The facility will remain out of compliance at a "E" level until it provides an acceptable plan of correction to include continued monitoring to ensure the deficient practice does not recur and the facility's corrective measure could be reviewed and evaluated by the Quality Assurance Committee. | {F 221} | and policies are being followed, if compliance is maintained audits will reduce to weekly audits times 90 days, then random audits as long as compliance is maintained. If at any time compliance is not met, daily audits will resume until compliance is obtained. The audit findings will be reviewed the morning Quality Assurance Meeting (Monday-Friday) and review with the Medical Director in the quarterly QA meeting and as needed.<br><br>**Completion Date: 3/22/12** | |



20

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 221} | Continued From page 2 | {F 221} | | |
| {F 226} SS=E | we<br>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES<br><br>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, review of facility investigations, facility policy review, and interview, the facility failed to report an allegation of abuse timely for three residents (#13, #10, #83) of four residents with allegations of abuse reviewed.<br><br>The findings included:<br><br>Resident #10 was admitted to the facility on September 9, 2011, with diagnoses including Cerebrovascular Accident, Diabetes, and Dementia.<br><br>Review of the facility investigation #1 investigated | {F 226} | **F 226**<br><br>**483.13(c) Develop/Implement Abuse/Neglect, Etc Policies**<br><br>**SS=E**<br><br>**Requirement:**<br><br>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.<br><br>**Correction Action Plan:**<br><br>1. A thorough investigation was conducted by Director of Nursing Services and the facility Administrator regarding the allegations of abuse for residents #13, 10, and 83on 11/14/12. The alleged suspect is no longer an | |



31

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 226} | Continued From page 3<br>by the Director of Nursing (DON), dated November 14, 2011, revealed "(Director of Nursing) received a call from the facility at 2230. (10:30 p.m.) The charge nurse on duty reported that (CNA #4) (certified nursing assistant) came to (Director of Nursing) and reported that another (CNA #5) had spoken to several residents in a mean and rude manner and that (CNA #5) had also gotten rough with their care, and that (CNA #4) was concerned about what to do to report it. The charge nurse stated that the CNA (#5) in question had already left for the evening. I instructed the charge nurse to go and question the residents. I ask the (CNA #4) why...did not report to the charge nurse on (CNA #4) shift, (CNA #4) stated that every time that I tried someone was at the nurses station..."<br><br>Resident #83 was admitted to the facility on March 16, 2011, with diagnoses including Dementia, Alzheimer's Disease, and Dysphagia.<br><br>Review of the facility investigation #2 investigated by the DON, dated November 14, 2011, revealed "upon arriving to work this am (CNA #4) was sitting in my office. (CNA #4) reported...was assisting (CNA #5) in providing care to (resident #83) (CNA #4) stated that (CNA #5) put both side rails down and roughly pushes (resident #83) over almost out of bed, and then pulled...towards (CNA #5), and states "you have to be rough with (resident #83) because (resident #83) holds stiff."<br><br>Resident #13 was admitted to the facility on March 21, 2008, with diagnoses including Alzheimer's Disease, Congestive Heart Failure, and Hypertension. | {F 226} | employee at the facility. Staffing patterns were reviewed to ensure that all residents are free from abuse.<br><br>2. The Social Worker interviewed residents with a BIM score greater than 13 on 3/20/12. The Nursing Administration team performed skin assessments to observe for signs of abuse for residents with BIM score less than 13 completed by 3/19/12. No new findings of abuse were noted.<br><br>3. An in-service was conducted by the Director of Nursing Services and the Administrator on 2/17/12, 2/27/12, 2/29/12 and 3/15/12 with direct care staff addressing the facility policies and procedures regarding alleged violations. An annual in-service is scheduled in September per facility policy and as needed.<br><br>4. The Social Service Director, or designee, will conduct random interviews of five (5) residents weekly for four (4) consecutive weeks. These residents will be interviewed to ensure that any alleged violations are identified, properly investigated and reported according to facility policy and procedures. Findings of this audit will be discussed in the morning Quality Assurance meeting and the quarterly QA Committee meeting. This plan of correction will be monitored at the monthly Patient Care | |



32

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 226} | Continued From page 4<br>Review of the facility investigation #3 investigated by the DON, dated November 14, 2011, revealed "(CNA #4) reported to (DON) that on (CNA #4) last round (CNA #5) assisted (CNA #4) in the care of (resident #13). (CNA #4) reported (CNA #5) roughly pushed (resident #13) over so...could clean (resident #13) (CNA #4) reported that (resident #13) stated...was going to fall out of bed and that (CNA #5) laughed and said that the rail was up...(CNA #4) reported that (CNA #5) got rude with resident #13...(CNA #4) reports (CNA #5) kept acting like...was going to pull resident off the bed...resident #13 got upset and told (CNA #5) to get out of the room..."<br><br>Review of the facility policy, Abuse Protection Policy, revealed "...Any report of actual or suspected abuse must be acted upon immediately...complete an investigation on all occurrences to include appropriate information..."<br><br>Interview with the DON in the small dining room on February 16, 2012, at 2:40 p.m., confirmed CNA #4 did not follow the facility policy and report the allegations of abuse immediately. | {F 226} | and Service meeting until such time consistent substantial compliance has been met.<br><br>**Completion date: 3/22/12**<br><br>**F 272**<br><br>**483.20(b)(1) Comprehensive Assessments**<br><br>**SS=E** | |
| {F 272} SS=E | 483.20(b)(1) COMPREHENSIVE ASSESSMENTS<br><br>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.<br><br>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at | {F 272} | **Requirement:**<br><br>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. | |



33

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 272} | Continued From page 5<br>least the following:<br>Identification and demographic information;<br>Customary routine;<br>Cognitive patterns;<br>Communication;<br>Vision;<br>Mood and behavior patterns;<br>Psychosocial well-being;<br>Physical functioning and structural problems;<br>Continence;<br>Disease diagnosis and health conditions;<br>Dental and nutritional status;<br>Skin conditions;<br>Activity pursuit;<br>Medications;<br>Special treatments and procedures;<br>Discharge potential;<br>Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and<br>Documentation of participation in assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, observation, and interview, the facility failed to conduct a comprehensive assessment on six residents (#41, #60, #18, #83, #55, #57) of forty three residents reviewed.<br><br>The facility provided a Credible Allegation of | {F 272} | **Corrective Action Plan:**<br><br>1. (a) Upon review of the Fall Risk Assessment on 2/6/12 completed by the licensed nurse the systematic review of risk factors indicated a risk score of 24 (high risk) for **resident #41.** Based on the risk factors from his Fall Risk Assessment it was determined that he was not a candidate for the use of side rails due to impaired judgment, incontinence, and history of falls from his bed. The side rails were removed on 2/6/12 by the Maintenance Director. The nursing administration staff communicated changes made to the resident's plan of care (removal of side rails and low bed with one mat) to the direct caregivers on the Nurse Aide Communication Worksheet and the Care plans on 2/6/12. On 2/17/12 a telephone order was obtained by the charge nurse and the Director of Nursing to discontinue the resident's bed and chair alarm and use a sensor pressure pad for his bed and chair. The resident remains on a low bed with one mat at bedside after receiving a telephone order from the physician on 2/23/12. The resident's care plan was updated on | |



34

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/201
FORM APPROVE
OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 272} | Continued From page 5<br>least the following:<br>Identification and demographic information;<br>Customary routine;<br>Cognitive patterns;<br>Communication;<br>Vision;<br>Mood and behavior patterns;<br>Psychosocial well-being;<br>Physical functioning and structural problems;<br>Continence;<br>Disease diagnosis and health conditions;<br>Dental and nutritional status;<br>Skin conditions;<br>Activity pursuit;<br>Medications;<br>Special treatments and procedures;<br>Discharge potential;<br>Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and<br>Documentation of participation in assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, observation, and interview, the facility failed to conduct a comprehensive assessment on six residents (#41, #60, #18, #83, #55, #57) of forty three residents reviewed.<br><br>The facility provided a Credible Allegation of | {F 272} | 2/24/12 by the Interim MDS Coordinator to reflect the current orders and interventions (other interventions: involve in activities, slip resistant footwear, may place in the sight of staff when awake, rest periods as needed, family at bedside sessions throughout the day, get patient up when trying to get out of bed, offer snacks, attempt to keep resident dry or clean immediately after incontinent episode). The care plan was audited by the Nursing Administration Staff to ensure that the plan of care had been updated to reflect the resident's current status on 2/24/12. *Resident* was hospitalized from 2/24/12 to 3/2/12, returning with a change in medical status. The Fall Risk Assessment updated on 3/5/12 by the Director of Nursing reflects that resident no longer attempts to self transfer, requiring assistance of 2 for transfers. The resident no longer requires constant supervision for the prevention of falls. He is on the FROG Program that provides closer observation from various staff members. Resident was transferred to the hospital again on 3/9/12 after visit by attending physician. MDS | |



35

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/20
FORM APPROVI
OMB NO. 0938-03

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETIO DATE |
|---|---|---|---|---|
| {F 272} | Continued From page 5<br>least the following:<br>Identification and demographic information;<br>Customary routine;<br>Cognitive patterns;<br>Communication;<br>Vision;<br>Mood and behavior patterns;<br>Psychosocial well-being;<br>Physical functioning and structural problems;<br>Continence;<br>Disease diagnosis and health conditions;<br>Dental and nutritional status;<br>Skin conditions;<br>Activity pursuit;<br>Medications;<br>Special treatments and procedures;<br>Discharge potential;<br>Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and<br>Documentation of participation in assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, observation, and interview, the facility failed to conduct a comprehensive assessment on six residents (#41, #60, #18, #83, #55, #57) of forty three residents reviewed.<br><br>The facility provided a Credible Allegation of | {F 272} | Coordinator completed a discharge assessment on 3/9/12. Resident was readmitted on 3/15/12 with admitting Charge Nurse completing Fall Risk Assessment and Evaluation for the Use of Side Rails with the recommendation to be that side rails were not indicated at that time. Resident's care plan was updated on 3/21/12 with a significant change assessment completed by the MDS Coordinator. Resident's care plan is updated per MDS and/or Charge Nurse on ongoing bases and as needed with any new orders, interventions, or changes.<br><br>(b) **Resident# 60** was discharged to the hospital on 2/26/12. The Interim MDS Coordinator completed a Discharge Assessment on 2/29/12 which reflected the use of side rails as a restraint. The resident will be reassessed upon return to the facility. The care plan was reviewed by the Interim MDS Coordinator and reflects the resident's current status as of 2/26/12. The care plan was audited by the Nursing Administration Staff to ensure that the plan of care had been updated to reflect the resident's current status on 2/26/12. | |



38

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/14/
FORM APPRO
OMB NO. 0938-(

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETI DATE |
|---|---|---|---|---|
| {F 272} | Continued From page 5<br>least the following:<br>Identification and demographic information;<br>Customary routine;<br>Cognitive patterns;<br>Communication;<br>Vision;<br>Mood and behavior patterns;<br>Psychosocial well-being;<br>Physical functioning and structural problems;<br>Continence;<br>Disease diagnosis and health conditions;<br>Dental and nutritional status;<br>Skin conditions;<br>Activity pursuit;<br>Medications;<br>Special treatments and procedures;<br>Discharge potential;<br>Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and<br>Documentation of participation in assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, observation, and interview, the facility failed to conduct a comprehensive assessment on six residents (#41; #60; #18; #83; #55; #57) of forty three residents reviewed.<br><br>The facility provided a Credible Allegation of | {F 272} | Resident was transferred to hospital on 2/26/12. The Interim MDS Coordinator completed a Discharge Assessment on 2/29/12 which reflected the use of side rails as a restraint (as ½ rails were used until 2/23/12 during the 7 day look back period). The resident was reassessed upon return to the facility on 3/12/12 by the admitting Charge Nurse who completed an Evaluation for the use of Side Rails and a Fall Risk Assessment with the recommendation for no side rails indicated at this time. The MDS Coordinator completed a 5 day Readmission Assessment on 3/22/12. (A 14 day Assessment was completed on 3/29/12). Resident's care plan is updated per MDS and/or Charge Nurse on an ongoing base and as needed with any new orders, interventions, or changes.<br><br>(c) **Resident #18** The side rails that were in place during the survey were immediately changed to full anti-entrapment rails on 2/6/12 by the Maintenance Director after receiving a physician's order. The measurements for the bed zones | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/20
FORM APPROVI
OMB NO. 0938-03

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETIO DATE |
|---|---|---|---|---|
| {F 272} | Continued From page 5<br>least the following:<br>Identification and demographic information;<br>Customary routine;<br>Cognitive patterns;<br>Communication;<br>Vision;<br>Mood and behavior patterns;<br>Psychosocial well-being;<br>Physical functioning and structural problems;<br>Continence;<br>Disease diagnosis and health conditions;<br>Dental and nutritional status;<br>Skin conditions;<br>Activity pursuit;<br>Medications;<br>Special treatments and procedures;<br>Discharge potential;<br>Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and<br>Documentation of participation in assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, observation, and interview, the facility failed to conduct a comprehensive assessment on six residents (#41, #60, #18, #83, #55, #57) of forty three residents reviewed.<br><br>The facility provided a Credible Allegation of | {F 272} | were obtained by the Maintenance Director on 2/6/12 using a standard tape measure with measurements. The Staffing Coordinator wrote a narrative note in the nurses notes on 2/6/12 describing the resident with limited functional status using the side rails as a restraint. A Physical Restraint Assessment was updated on 2/6/12 by the Staffing Coordinator for the use of side rails. A Side Rail Assessment and Informed Consent was signed by the family on 2/13/12. On 2/20/12 the MDS Coordinator completed an Evaluation for use of Side Rails with a reduction in side rails from full (anti-entrapment) to ½ rails, the physician was notified and order was obtained for ½ side rails. The measurements for the bed zones were obtained by the Maintenance Director on 2/20/12. On 2/23/12 the resident was evaluated again for side rail reduction by the Staffing Coordinator, the resident's side rails was | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2
FORM APPROV
OMB NO. 0938-0

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETIC DATE |
|---|---|---|---|---|
| {F 272} | Continued From page 5<br>least the following:<br>Identification and demographic information;<br>Customary routine;<br>Cognitive patterns;<br>Communication;<br>Vision;<br>Mood and behavior patterns;<br>Psychosocial well-being;<br>Physical functioning and structural problems;<br>Continence;<br>Disease diagnosis and health conditions;<br>Dental and nutritional status;<br>Skin conditions;<br>Activity pursuit;<br>Medications;<br>Special treatments and procedures;<br>Discharge potential;<br>Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and<br>Documentation of participation in assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, observation, and interview, the facility failed to conduct a comprehensive assessment on six residents (#41, #60, #18, #83, #55, #57) of forty three residents reviewed.<br><br>The facility provided a Credible Allegation of | {F 272} | eliminated and the resident was placed on a low bed with mats. On 3/5/12 resident rolled out of bed with a small laceration to upper lip with intervention to check placement of furniture and remove if in pathway. Keep room free of clutter for safety, Bowel and bladder program to determine habit time, and FROG Program. Care plan was updated to reflect new interventions for 3/5. 3/13 resident was found in room 129 bathroom with one shoe on. Resident had gotten up from her wheel chair in another resident's room, with interventions for proper footwear (nonskid) replace footwear when resident removes as allows with physical therapy to screen. On 3/15, further intervention was added to get up after breakfast as desires after further investigation of fall on 3/13. Fall on 3/17 where resident rolled from the bed in her sleep, bed was in lowest position with mats on both sides, no injury | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2
FORM APPROV
OMB NO. 0938-0

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETIO DATE |
|---|---|---|---|---|
| {F 272} | Continued From page 5<br>least the following:<br>Identification and demographic information;<br>Customary routine;<br>Cognitive patterns;<br>Communication;<br>Vision;<br>Mood and behavior patterns;<br>Psychosocial well-being;<br>Physical functioning and structural problems;<br>Continence;<br>Disease diagnosis and health conditions;<br>Dental and nutritional status;<br>Skin conditions;<br>Activity pursuit;<br>Medications;<br>Special treatments and procedures;<br>Discharge potential;<br>Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and<br>Documentation of participation in assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, observation, and interview, the facility failed to conduct a comprehensive assessment on six residents (#41, #60, #18, #83, #55, #57) of forty three residents reviewed.<br><br>The facility provided a Credible Allegation of | {F 272} | noted, intervention to add pool noodles to define perimeter of the bed with all above interventions added to the care plan as implemented. Resident's care plan is updated per MDS and/or Charge Nurse on an ongoing bases and as needed with any new orders, interventions, or changes. Assessment was completed on 2/28/12 by the Staffing Coordinator for the elimination of side rails and the use of a low bed with mats after receiving a physician's order. The care plan was audited by the Nursing Administration Staff to ensure that the plan of care had been updated to reflect the resident's current status on 2/29/12.<br><br>(d) **Resident #83** *The recapitalization orders were signed by the physician for 2/2/12 included an order for the use of side rails. An assessment was completed on 2/6/12 using a Pre-Restraint Assessment for the use of ¾ side rails completed by the* | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 272} | Continued From page 5<br>least the following:<br>Identification and demographic information;<br>Customary routine;<br>Cognitive patterns;<br>Communication;<br>Vision;<br>Mood and behavior patterns;<br>Psychosocial well-being;<br>Physical functioning and structural problems;<br>Continence;<br>Disease diagnosis and health conditions;<br>Dental and nutritional status;<br>Skin conditions;<br>Activity pursuit;<br>Medications;<br>Special treatments and procedures;<br>Discharge potential;<br>Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and<br>Documentation of participation in assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, observation, and interview, the facility failed to conduct a comprehensive assessment on six residents (#41, #60, #18, #83, #55, #57) of forty three residents reviewed.<br><br>The facility provided a Credible Allegation of | {F 272} | *MDS Coordinator indicating a restraint was recommended related to cognitive impairment, requiring physical assistance, and unaware of safety issues.* An order was obtained on 2/6/12 from the resident's physician for the use of side rails as a restraint. On 2/20/12 an Evaluation for the use of Side Rail Assessment was completed by the MDS Coordinator indicating the resident was unaware of safety needs, cognitive impairment, and requiring physical assistance with the utilization of ¾ side rails. A new Evaluation for the use of Side Rails was completed on 2/23/12 by the Director of Nursing for the reduction of side rails from ¾ to ½. The resident's Physical Restraint Assessment was updated on 2/23/12 by the Director of Nursing for the restraint reduction and new orders received for the use of ½ side rails. On 2/28/12, an Evaluation for the use of Side Rails and Physical Restraint Assessment | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 272} | Continued From page 5<br>least the following:<br>Identification and demographic information;<br>Customary routine;<br>Cognitive patterns;<br>Communication;<br>Vision;<br>Mood and behavior patterns;<br>Psychosocial well-being;<br>Physical functioning and structural problems;<br>Continence;<br>Disease diagnosis and health conditions;<br>Dental and nutritional status;<br>Skin conditions;<br>Activity pursuit;<br>Medications;<br>Special treatments and procedures;<br>Discharge potential;<br>Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and<br>Documentation of participation in assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, observation, and interview, the facility failed to conduct a comprehensive assessment on six residents (#41, #60, #18, #83, #55, #57) of forty three residents reviewed.<br><br>The facility provided a Credible Allegation of | {F 272} | was completed by the Director of Nursing indicating the elimination of ½ rails and placed on low bed with mats. The care plan was audited by the Nursing Administration Staff to ensure that the plan of care had been updated to reflect the resident's current status on 2/29/12. Care plan is current to resident's status and is updated per MDS and/or Charge Nurse on an ongoing bases and as needed with any new orders, interventions, or changes.<br><br>(e) **Resident # 55** expired on 2/16/12. No further assessments or modifications can be completed for this resident.<br><br>(f) **Resident # 57** A telephone order was received from the resident's physician for the use of ½ side rails on 2/10/12. The resident was assessed on 2/20/12 using the Evaluation for use of Side Rails (for the evaluation of | |



42

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 272} | Continued From page 5<br>least the following:<br>Identification and demographic information;<br>Customary routine;<br>Cognitive patterns;<br>Communication;<br>Vision;<br>Mood and behavior patterns;<br>Psychosocial well-being;<br>Physical functioning and structural problems;<br>Continence;<br>Disease diagnosis and health conditions;<br>Dental and nutritional status;<br>Skin conditions;<br>Activity pursuit;<br>Medications;<br>Special treatments and procedures;<br>Discharge potential;<br>Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and<br>Documentation of participation in assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, observation, and interview, the facility failed to conduct a comprehensive assessment on six residents (#41, #60, #18, #83, #55, #57) of forty three residents reviewed.<br><br>The facility provided a Credible Allegation of | {F 272} | side rail use) indicating the use of ½ side rails by the Staffing Coordinator. A Pre-Restraint Assessment was completed on 2/21/12 by the Director of Nursing that indicated side rails are used as a restraint. On 2/24/12 another Evaluation for the use of Side Rail was completed by the Staffing Coordinator indicating the elimination of ½ side rails (no side rails are in place at this time). As of 2/24/12 the resident's current interventions include: the locking of wheel chair prior to transfer, offer rest periods, assist to the bathroom during rounds and as needed, bed in lowest position, a chair sensor pad. The care plan was audited by the Nursing Administration Staff to ensure that the plan of care had been updated to reflect the resident's current status on 2/29/12. The care plan was audited by the Nursing Administration Staff to ensure that the plan of care had been updated to reflect the resident's | |



43

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 272} | Continued From page 5<br>least the following:<br>Identification and demographic information;<br>Customary routine;<br>Cognitive patterns;<br>Communication;<br>Vision;<br>Mood and behavior patterns;<br>Psychosocial well-being;<br>Physical functioning and structural problems;<br>Continence;<br>Disease diagnosis and health conditions;<br>Dental and nutritional status;<br>Skin conditions;<br>Activity pursuit;<br>Medications;<br>Special treatments and procedures;<br>Discharge potential;<br>Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and<br>Documentation of participation in assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, observation, and interview, the facility failed to conduct a comprehensive assessment on six residents (#41, #60, #18, #83, #55, #57) of forty three residents reviewed.<br><br>The facility provided a Credible Allegation of | {F 272} | current status on 2/29/12. The resident's care plan was reviewed by the Director of Nursing on 3/7/12 and evaluated for fall prevention strategies and deemed the intervention for constant supervision during toileting was inappropriate. After review of current interventions on 3/7/12 by the Director of Nursing and further investigation of the leave unattended) it was determined that the intervention was implemented before a full root cause analysis was conducted (the intervention was removed as of 2/24/12 interventions above). As of 3/22/12, current interventions, the resident remains on the FROG program, participates in restorative with ambulation "walk to dine program", low bed with mats, antiroll back brakes, the locking of wheel chair prior to transfer, offer rest periods, assist to the bathroom during rounds and as needed, further monitoring and interventions will continue to prevent falls. Resident's care plan is current and updated per MDS and/or Charge Nurse on | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/20
FORM APPROVE
OMB NO. 0938-03

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 272} | Continued From page 5<br>least the following:<br>Identification and demographic information;<br>Customary routine;<br>Cognitive patterns;<br>Communication;<br>Vision;<br>Mood and behavior patterns;<br>Psychosocial well-being;<br>Physical functioning and structural problems;<br>Continence;<br>Disease diagnosis and health conditions;<br>Dental and nutritional status;<br>Skin conditions;<br>Activity pursuit;<br>Medications;<br>Special treatments and procedures;<br>Discharge potential;<br>Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and<br>Documentation of participation in assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, observation, and interview, the facility failed to conduct a comprehensive assessment on six residents (#41, #60, #18, #83, #55, #57) of forty three residents reviewed.<br><br>The facility provided a Credible Allegation of | {F 272} | an ongoing bases and as needed with any new orders, interventions, or changes.<br><br>2. A review of all residents MDS's and Care Plans was initiated on 2/28/12 and completed by 3/5/12 to identify other assessments that may not have been coded or updated correctly for the use of side rails/restraints. Ten residents were identified as needing changes made to a current or previous assessment (MDS) for the use of side rails, all of the ten were completed between 2/28/12 and 3/5/12 by the MDS Coordinator(s).<br><br>3. The Regional Nurse Consultant in-serviced the MDS Coordinator and the Staffing Coordinator/Back Up MDS Coordinator on 2/21/12 and 2/22/12 on the completion of accurate assessments and developing/revision of care plans to reflect the resident's current medical condition. The MDS | |



45

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 272} | Continued From page 5<br>least the following:<br>Identification and demographic information;<br>Customary routine;<br>Cognitive patterns;<br>Communication;<br>Vision;<br>Mood and behavior patterns;<br>Psychosocial well-being;<br>Physical functioning and structural problems;<br>Continence;<br>Disease diagnosis and health conditions;<br>Dental and nutritional status;<br>Skin conditions;<br>Activity pursuit;<br>Medications;<br>Special treatments and procedures;<br>Discharge potential;<br>Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and<br>Documentation of participation in assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, observation, and interview, the facility failed to conduct a comprehensive assessment on six residents (#41; #60; #18; #83; #55; #57) of forty three residents reviewed.<br><br>The facility provided a Credible Allegation of | {F 272} | Coordinator will obtain a physician's order, initiate a Pre-Restraint Assessment, complete an Evaluation for the Use of Side Rails, and obtain a Side Rail Assessment and Informed Consent form for newly coded side rails on the MDS, along with revising the resident's care plan. If the side rail is a continuation from the resident's previous assessment, a Physical Restraint Assessment will be reviewed and updated to determine if the resident is a candidate for restraint reduction. The Interdisciplinary Team (not limited to: Director/Assistant Director of Nursing, MDS Coordinator, Social Services, and Activity Director) will also discuss residents with restraints monthly in their Fall Focus Meeting for modification and/or reduction. Resident and families will be notified of scheduled care plan meetings by the MDS Coordinator prior to the residents next scheduled assessment and/or | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 272} | Continued From page 5<br>least the following:<br>Identification and demographic information;<br>Customary routine;<br>Cognitive patterns;<br>Communication;<br>Vision;<br>Mood and behavior patterns;<br>Psychosocial well-being;<br>Physical functioning and structural problems;<br>Continence;<br>Disease diagnosis and health conditions;<br>Dental and nutritional status;<br>Skin conditions;<br>Activity pursuit;<br>Medications;<br>Special treatments and procedures;<br>Discharge potential;<br>Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and<br>Documentation of participation in assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, observation, and interview, the facility failed to conduct a comprehensive assessment on six residents (#41, #60, #18, #83, #55, #57) of forty three residents reviewed.<br><br>The facility provided a Credible Allegation of | {F 272} | as needed to assist in developing a plan of care that meets the resident's personal/medical goals. The MDS Coordinator will utilize information provided in the morning QA meeting, 24 hour report, resident's medical record, and communication from staff, residents, and/or families when completing resident assessments to ensure accuracy. On 2/23/12 the Interim MDS Coordinator was in-serviced by the Regional Nurse Consultant on accuracy when completing MDS's and the development and revision of care plans, along with recent survey deficiencies. On 3/5/12 the Regional Nurse Consultant in-serviced the MDS Coordinator on documenting (communication) changes made to the resident's plan of care on the 24 hour report.<br><br>4. The Interdisciplinary Team will review all completed MDSs and Care Plans for accuracy, making revisions as needed daily (Monday-Friday) in the morning QA meeting. The Director or | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/20
FORM APPROVE
OMB NO. 0938-03

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 272} | Continued From page 5<br>least the following:<br>Identification and demographic information;<br>Customary routine;<br>Cognitive patterns;<br>Communication;<br>Vision;<br>Mood and behavior patterns;<br>Psychosocial well-being;<br>Physical functioning and structural problems;<br>Continence;<br>Disease diagnosis and health conditions;<br>Dental and nutritional status;<br>Skin conditions;<br>Activity pursuit;<br>Medications;<br>Special treatments and procedures;<br>Discharge potential;<br>Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and<br>Documentation of participation in assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, observation, and interview, the facility failed to conduct a comprehensive assessment on six residents (#41, #60, #18, #83, #55, #57) of forty three residents reviewed.<br><br>The facility provided a Credible Allegation of | {F 272} | Assistant Director of Nursing will review MDSs and Care Plans to ensure compliance is met for the next 90 days; then weekly for 90 days if compliance has been maintained; then randomly thereafter. If at any point compliance is not met, the party will resume monitoring daily (Monday-Friday) until compliance is maintained. The Director or Assistant Director of Nursing will review findings related to the audits in the quarterly QA Committee.<br><br>**Completion Date: 3/22/12** | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 272} | Continued From page 6<br>Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included:<br><br>Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The facility provided evidence Pre-Restraint Assessments and Physical Restraint Assessments were completed when indicated. The facility provided evidence of fall risk assessments and side rail assessments were completed for all residents, with removal of side rails when indicated. The facility provided evidence of in-service for all staff and random audits to ensure compliance.<br><br>The facility will remain out of compliance at a "E" level until it provides an acceptable plan of correction to include continued monitoring to ensure the deficient practice does not recur and the facility's corrective measure could be reviewed and evaluated by the Quality Assurance Committee. | {F 272} | | |
| {F 278} SS=E | 483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED<br><br>The assessment must accurately reflect the resident's status.<br><br>A registered nurse must conduct or coordinate | {F 278} | F 278<br><br>**483.20(g)-(j) Assessment Accuracy/Coordination/Certified**<br><br>**SS=E** | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 278} | Continued From page 7<br>each assessment with the appropriate participation of health professionals.<br><br>A registered nurse must sign and certify that the assessment is completed.<br><br>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.<br><br>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.<br><br>Clinical disagreement does not constitute a material and false statement.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review and interview, the facility failed to ensure the Minimum Data Set (MDS) was accurate for four (#41, #53, #57 and #23) residents of forty-three residents reviewed.<br><br>The findings included:<br><br>Resident #41 was admitted to the facility on September 23, 2011, and readmitted to the facility on October 24, 2011, with diagnoses including Alzheimer's Disease, Dementia, Bipolar, | {F 278} | **Requirements:**<br><br>The assessment must accurately reflect the resident's status. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.<br><br>**Corrective Action Plan:**<br><br>1. (a) Resident #41 was reassessed with modifications made to the previous assessment on 2/28/12 by the MDS Coordinator to include: Dementia, Bipolar, Anxiety, and Deep Vein Thrombosis diagnoses.<br><br>(b) Resident #53 was reassessed with modifications made to the previous assessment on 2/28/12 by the MDS Coordinator to include: Dysphagia.<br><br>(c) Resident #57 was reassessed with modifications made to a previous assessment on 2/29/12 by the MDS Coordinator to include: previous fall.<br><br>(d) The resident #23 was discharged to the hospital on 1/3/12 and did not return to the facility. His MDS assessment could not be corrected. | |



50

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/201
FORM APPROVE
OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 278} | Continued From page 8<br>Anxiety, Deep Vein Thrombosis and Colon Cancer.<br><br>Medical record review of the MDS dated January 23, 2012, revealed no documentation of the Dementia, Bipolar, Anxiety, and Deep Vein Thrombosis diagnoses.<br><br>Interview with the MDS Coordinator on February 17, 2012, at 8:45 a.m., in the MDS office, confirmed the MDS dated January 23, 2012, did not include the diagnoses of Dementia, Bipolar, Anxiety, and Deep Vein Thrombosis and the MDS was not accurate.<br><br>Resident #53 was readmitted to the facility on October 23, 2011, with diagnoses of Dementia, Aphasia, Dysphasia, Cardiovascular Accident and Left Frontal Hematoma.<br><br>Medical record review of physician consult dated November 23, 2011, revealed "...dysphasia...throat problems..."<br><br>Medical record review of the Minimum Data Set dated January 13, 2012, revealed no documentation of the diagnosis of Dysphagia.<br><br>Interview with the MDS Coordinator on February 17, 2012, at 8:45 a.m., in the MDS office, confirmed the MDS dated January 13, 2012, did not include the diagnoses of Dysphasia, and the MDS was not accurate.<br><br>Resident #57 was admitted to the facility on November 11, 2011, with diagnoses including Alzheimer's Disease, Hypertension, and Senile Dementia. | {F 278} | 2. A review of all residents MDS's and Care Plans was completed on 3/16/12 to identify other assessments that may not have been coded accurately with corrections made as needed by the MDS Coordinator(s). A review of all residents MDS's and Care Plans was initiated on 2/28/12 and completed by 3/5/12 to identify other assessments that may not have been coded or updated correctly for the use of side rails/restraints. Ten residents were identified as needing changes made to a current or previous assessment (MDS) for the use of side rails, all of the ten were completed between 2/28/12 and 3/5/12 by the MDS Coordinator(s).<br><br>3. On 2/21/12 and 2/22/12 the Interim MDS Coordinator and the Interdisciplinary team was in-serviced by the Administrator in the presence of the Regional Nurse Consultant on accuracy when completing MDS's and the development and revision of care plans, along with recent survey | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/201
FORM APPROVED
OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 278} | Continued From page 9<br><br>Medical record review of the Minimum Data Set (MDS) dated January 4, 2012, revealed "...severe cognitive impairment...independent for locomotion on and off the unit...side rails used daily for restraints...chair to prevent rising...one fall with injury..." since prior assessment dated October 12, 2011. Continued review of the MDS dated January 4, 2012, revealed there were no falls without injury.<br><br>Medical record review of a Nurse's Event Note dated November 22, 2011, revealed a fall with injury, and Nurse's Event Notes dated December 10, 2011, and revealed a fall without injuries.<br><br>Interview on February 17, 2012, at 8:50 a.m., with the MDS Coordinator, in the MDS office, confirmed the MDS dated January 4, 2012, did not reflect the fall the resident had experienced on December 10, 2011, and confirmed the MDS was not accurate.<br>Resident #23 was admitted to the facility on March 12, 2010, with diagnoses including Dementia, Coronary Artery Disease, Hypertension, Congestive Heart Failure, Peripheral Vascular Disease, and Pernicious Anemia.<br><br>Medical record review of the Nursing Notes dated August 14, 2011, revealed "...refusing to put 02 on...cussing and yelling secondary to not being able to go on back porch..."<br><br>Medical record review of the Nursing Notes dated August 15, 2011, revealed "...Resident screaming 'nursey nursey'...Refused all 2000 (8:00 p.m.) meds (medications)..." | {F 278} | deficiencies. The Regional Nurse Consultant in-serviced the MDS Coordinator and the Staffing Coordinator/Back-Up MDS Coordinator on 2/22/12 on the completion of accurate assessments and developing/revision of care plans to reflect the resident's current medical condition.<br><br>4. The Director of Nursing Services, or designee, will conduct a random audit of three (3) residents per week to ensure that diagnoses, behaviors, and falls are captured correctly for four (4) consecutive weeks. These residents and their medical records will be assessed to ensure that the MDS assessment is a true reflection of the resident's status at the time of the assessment. Findings of this audit will be discussed in the morning Quality Assurance meeting and the quarterly QA Committee until such time consistent substantial compliance has been met.<br><br>**Completion date: 3/22/12** | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 278} | Continued From page 10<br><br>Medical record review of the Nursing Notes dated August 16, 2011, revealed "...yelling out at times to care givers..."<br><br>Medical record review of the Nursing Notes dated August 17, 2011, revealed "...Cont (continues) to yell out frequently. When approached curses staff. Drawing back fist to strike at staff...Awake most of night yelling out 'nurse' unable to redirect..."<br><br>Medical record review of the Nursing Notes dated August 18, 2011, revealed "...refusing to wear 02..."<br><br>Medical record review of the Nursing Notes dated August 19, 2011, revealed "Resident cussing at staff during care. Cont (continues) to refuse thickened liquids-going to BR (bathroom) and getting H2O (water). Refusing to wear 02 when up in w/c (wheelchair). O2 sat (saturation) 90% RA (room air)..."<br><br>Medical record review of the Nursing Notes dated August 20, 2011, revealed the resident was repeatedly removing 02 (oxygen); had increased agitation; and Ativan (antianxiety medication) had been administered without effect.<br><br>Medical record review of the Minimum Data Set (MDS) dated August 20, 2011, revealed the resident exhibited no behaviors.<br><br>Interview on February 15, 2012, at 3:35 p.m., with the Social Worker, in the MDS office, confirmed the MDS dated August 20, 2011, did not reflect the resident's behaviors and confirmed the MDS | {F 278} | | |

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 278} | Continued From page 11<br>was not accurate.<br><br>Refer to F221- Substandard Quality of Care- resident's right to be free from physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.<br><br>Refer to 272 - facility must make a comprehensive, accurate, standardized assessment of each resident's need, and functional capacity.<br><br>Refer to F323 - Substandard Quality of Care - facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. | {F 278} | | |
| {F 280} SS=E | 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP<br><br>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.<br><br>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed | {F 280} | | |



54

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 280} | Continued From page 12<br>and revised by a team of qualified persons after each assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, observation, and interview the facility failed to evaluate and update the Care Plan for seven residents (#41, #60, #18, #83, #52, #55 and #57) of forty three residents reviewed.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included:<br><br>Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The facility provided evidence Care Plans were reviewed and revised for all residents to reflect the residents current status. The facility provided evidence of in-service for all staff and random audits to ensure compliance.<br><br>The facility will remain out of compliance at a "E" level until it provides an acceptable plan of correction to include continued monitoring to | {F 280} | **F 280**<br><br>**483.20(d)(3) 483.10(k)(2) Right To Participate Planning Care-Revision CP**<br><br>**SS=E**<br><br>**Requirement:**<br><br>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment of changes in care and treatment.<br><br>**Corrective Action Plan:**<br><br>1. (a) Upon review of the Fall Risk Assessment on 2/6/12 completed by the licensed nurse the systematic review of risk factors indicated a risk score of 24 (high risk) for **resident #41.** Based on the risk factors from his Fall Risk Assessment it was determined that he was not a candidate for the use of side rails due to impaired | |



56

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/201
FORM APPROVEI
OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 280} | Continued From page 12<br>and revised by a team of qualified persons after each assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, observation, and interview the facility failed to evaluate and update the Care Plan for seven residents (#41, #60, #18, #83, #52, #55 and #57) of forty three residents reviewed.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included:<br><br>Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The facility provided evidence Care Plans were reviewed and revised for all residents to reflect the residents current status. The facility provided evidence of in-service for all staff and random audits to ensure compliance.<br><br>The facility will remain out of compliance at a "E" level until it provides an acceptable plan of correction to include continued monitoring to | {F 280} | judgment, incontinence, and history of falls from his bed. The side rails were removed on 2/6/12 by the Maintenance Director. The nursing administration staff communicated changes made to the resident's plan of care (removal of side rails and low bed with one mat) to the direct caregivers on the Nurse Aide Communication Worksheet and the Care plans on 2/6/12. On 2/17/12 a telephone order was obtained by the charge nurse and the Director of Nursing to discontinue the resident's bed and chair alarm and use a sensor pressure pad for his bed and chair.<br><br>The resident remains on a low bed with one mat at bedside after receiving a telephone order from the physician on 2/23/12. The resident's care plan was updated on 2/24/12 by the Interim MDS Coordinator to reflect the current orders and interventions (other interventions: involve in activities, slip resistant footwear, may place in the sight of staff when awake, rest periods as needed, family at bedside sessions throughout the day, get patient up when trying to get out of bed, offer snacks, attempt | |



56

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/20
FORM APPROVE
OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 280} | Continued From page 12<br>and revised by a team of qualified persons after each assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, observation, and interview the facility failed to evaluate and update the Care Plan for seven residents (#41, #60, #18, #83, #52, #55 and #57) of forty three residents reviewed.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included:<br><br>Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The facility provided evidence Care Plans were reviewed and revised for all residents to reflect the residents current status. The facility provided evidence of in-service for all staff and random audits to ensure compliance.<br><br>The facility will remain out of compliance at a "E" level until it provides an acceptable plan of correction to include continued monitoring to | {F 280} | to keep resident dry or clean immediately after incontinent episode). The care plan was audited by the Nursing Administration Staff to ensure that the plan of care had been updated to reflect the resident's current status on 2/24/12. Resident was hospitalized from 2/24/12 to 3/2/12, returning with a change in medical status. The Fall Risk Assessment updated on 3/5/12 by the Director of Nursing reflects that resident no longer attempts to self transfer, requiring assistance of 2 for transfers. The resident no longer requires constant supervision for the prevention of falls. He is on the FROG Program that provides closer observation from various staff members. Resident was transferred to the hospital again on 3/9/12 after visit by attending physician. MDS Coordinator completed a discharge assessment on 3/9/12. Resident was readmitted on 3/15/12 with admitting Charge Nurse completing Fall Risk Assessment and Evaluation for the Use of Side Rails with the recommendation to | |



51

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 280} | Continued From page 12<br>and revised by a team of qualified persons after each assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, observation, and interview the facility failed to evaluate and update the Care Plan for seven residents (#41, #60, #18, #83, #52, #55 and #57) of forty three residents reviewed.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included:<br><br>Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The facility provided evidence Care Plans were reviewed and revised for all residents to reflect the residents current status. The facility provided evidence of in-service for all staff and random audits to ensure compliance.<br><br>The facility will remain out of compliance at a "E" level until it provides an acceptable plan of correction to include continued monitoring to | {F 280} | be that side rails were not indicated at that time. Resident's care plan was updated on 3/21/12 with a significant change assessment. Resident's care plan is updated per MDS and/or Charge Nurse on ongoing bases and as needed with any new orders, interventions, or changes.<br><br>(b) **Resident #60's** care plan has been reviewed by the Interim MDS Coordinator and reflects the resident's current status as of 2/26/12. Resident was transferred to hospital on 2/26/12. The Interim MDS Coordinator completed a Discharge Assessment on 2/29/12 which reflected the use of side rails as a restraint (as ½ rails were used until 2/23/12 during the 7 day look back period). The resident was reassessed upon return to the facility on 3/12/12 by the admitting Charge Nurse who completed an Evaluation for the use of Side Rails and a Fall Risk Assessment with the | |



58

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/201
FORM APPROVE
OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 280} | Continued From page 12<br>and revised by a team of qualified persons after each assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, observation, and interview the facility failed to evaluate and update the Care Plan for seven residents (#41, #60, #18, #83, #52, #55 and #57) of forty three residents reviewed.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included:<br><br>Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The facility provided evidence Care Plans were reviewed and revised for all residents to reflect the residents current status. The facility provided evidence of in-service for all staff and random audits to ensure compliance.<br><br>The facility will remain out of compliance at a "E" level until it provides an acceptable plan of correction to include continued monitoring to | {F 280} | recommendation for no side rails indicated at this time. The MDS Coordinator completed a 5 day Readmission Assessment on 3/22/12. (A 14 day Assessment was completed on 3/29/12). Resident's care plan is updated per MDS and/or Charge Nurse on an ongoing base and as needed with any new orders, interventions, or changes.<br><br>**(c) Resident #18** The side rails that were in place during the survey were immediately changed to full anti-entrapment rails on 2/6/12 by the Maintenance Director after receiving a physician's order. The measurements for the bed zones were obtained by the Maintenance Director on 2/6/12 using a standard tape measure with measurements. The Staffing Coordinator wrote a narrative note in the nurses notes on 2/6/12 describing the resident with limited functional status using the side rails as a restraint. A Physical | |



59

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 280} | Continued From page 12<br>and revised by a team of qualified persons after each assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, observation, and interview the facility failed to evaluate and update the Care Plan for seven residents (#41, #60, #18, #83, #52, #55 and #57) of forty three residents reviewed.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included:<br><br>Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The facility provided evidence Care Plans were reviewed and revised for all residents to reflect the residents current status. The facility provided evidence of in-service for all staff and random audits to ensure compliance.<br><br>The facility will remain out of compliance at a "E" level until it provides an acceptable plan of correction to include continued monitoring to | {F 280} | Restraint Assessment was updated on 2/6/12 by the Staffing Coordinator for the use of side rails. A Side Rail Assessment and Informed Consent was signed by the family on 2/13/12. On 2/20/12 the MDS Coordinator completed an Evaluation for use of Side Rails with a reduction in side rails from full (anti-entrapment) to ½ rails, the physician was notified and order was obtained for ½ rails. The measurements for the bed zones were obtained by the Maintenance Director on 2/20/12. On 2/23/12 the resident was evaluated again for side rail reduction by the Staffing Coordinator, the resident's side rails was eliminated and the resident was placed on a low bed with mats. The Physical Restraint Assessment was completed on 2/28/12 by the Staffing Coordinator for the elimination of side rails and the use of a low bed with mats after receiving a physician's order. The care plan was audited by the Nursing | |



60

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 280} | Continued From page 12<br>and revised by a team of qualified persons after each assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, observation, and interview the facility failed to evaluate and update the Care Plan for seven residents (#41, #60, #18, #83, #52, #55 and #57) of forty three residents reviewed.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included:<br><br>Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The facility provided evidence Care Plans were reviewed and revised for all residents to reflect the residents current status. The facility provided evidence of in-service for all staff and random audits to ensure compliance.<br><br>The facility will remain out of compliance at a "E" level until it provides an acceptable plan of correction to include continued monitoring to | {F 280} | Administration Staff to ensure that the plan of care had been updated to reflect the resident's current status on 2/29/12. On 3/5/12 resident rolled out of bed with a small laceration to upper lip with intervention to check placement of furniture and remove if in pathway. Keep room free of clutter for safety, Bowel and bladder program to determine habit time, and FROG Program. Care plan was updated to reflect new interventions for 3/5. 3/13 resident was found in room 129 bathroom with one shoe on. Resident had gotten up from her wheel chair in another resident's room, with interventions for proper footwear (nonskid) replace footwear when resident removes as allows with physical therapy to screen. On 3/15, further intervention was added to get up after breakfast as desires after further investigation of fall on | |



61

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 280} | Continued From page 12<br>and revised by a team of qualified persons after each assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, observation, and interview the facility failed to evaluate and update the Care Plan for seven residents (#41, #60, #18, #83, #52, #55 and #57) of forty three residents reviewed.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included:<br><br>Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The facility provided evidence Care Plans were reviewed and revised for all residents to reflect the residents current status. The facility provided evidence of in-service for all staff and random audits to ensure compliance.<br><br>The facility will remain out of compliance at a "E" level until it provides an acceptable plan of correction to include continued monitoring to | {F 280} | 3/13. Fall on 3/17 where resident rolled from the bed in her sleep, bed was in lowest position with mats on both sides, no injury noted, intervention to add pool noodles to define perimeter of the bed with all above interventions added to the care plan as implemented. Resident's care plan is updated per MDS and/or Charge Nurse on an ongoing bases and as needed with any new orders, interventions, or changes.<br><br>(d) **Resident #83's** care plan was reviewed and modified by the Interim MDS Coordinator and reflects the resident's current status as of 2/29/12. On 2/28/12, an Evaluation for the use of Side Rails and Physical Restraint Assessment was completed by the Director of Nursing indicating the elimination of ½ rails and placed on low bed with mats. The care plan was audited by the Nursing Administration Staff to ensure that the plan of care had been updated to reflect the resident's | |



62

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2
FORM APPROVI
OMB NO. 0938-03

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 280} | Continued From page 12<br>and revised by a team of qualified persons after each assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, observation, and interview the facility failed to evaluate and update the Care Plan for seven residents (#41, #60, #18, #83, #52, #55 and #57) of forty three residents reviewed.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included:<br><br>Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The facility provided evidence Care Plans were reviewed and revised for all residents to reflect the residents current status. The facility provided evidence of in-service for all staff and random audits to ensure compliance.<br><br>The facility will remain out of compliance at a "E" level until it provides an acceptable plan of correction to include continued monitoring to | {F 280} | current status on 2/29/12. Care plan is current to resident's status and is updated per MDS and/or Charge Nurse on an ongoing bases and as needed with any new orders, interventions, or changes.<br><br>(e) **Resident #52's** care plan was reviewed and modified by the Interim MDS Coordinator and reflects the resident's current status as of 2/29/12. Care plan is current to resident's status and is updated per MDS and/or Charge Nurse on an ongoing bases and as needed with any new orders, interventions, or changes.<br><br>(f) . **Resident # 55's** care plan was reviewed and modified (the removal of placing at the nursing station, the following interventions remained in effect as of 2/14/12: assist with transfers as needed, FROG program, geri chair when out of bed) on 2/14/12 by the MDS Coordinator and reflected the | |



63

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/20
FORM APPROVE
OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 280} | Continued From page 12<br>and revised by a team of qualified persons after each assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, observation, and interview the facility failed to evaluate and update the Care Plan for seven residents (#41, #60, #18, #83, #52, #55 and #57) of forty three residents reviewed.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included:<br><br>Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The facility provided evidence Care Plans were reviewed and revised for all residents to reflect the residents current status. The facility provided evidence of in-service for all staff and random audits to ensure compliance.<br><br>The facility will remain out of compliance at a "E" level until it provides an acceptable plan of correction to include continued monitoring to | {F 280} | resident's current status. The resident's physical status changed as of 1/24/12 and the resident no longer required constant supervision. No further assessments or care plan updates could be completed due to the resident expiring on 2/16/12.<br><br>(g) **Resident # 57** A telephone order was received from the resident's physician for the use of ½ side rails on 2/10/12. The resident was assessed on 2/20/12 using the Evaluation for use of Side Rails (for the evaluation of side rail use) indicating the use of ½ side rails by the Staffing Coordinator. A Pre-Restraint Assessment was completed on 2/21/12 by the Director of Nursing that indicated side rails are used as a restraint. On 2/24/12 another Evaluation for the use of Side Rail was completed by the Staffing Coordinator indicating the elimination of ½ side rails (no side rails are in place at this time). As of 2/24/12 the resident's current interventions include: the locking of wheel chair prior to | |



64

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 280} | Continued From page 12<br>and revised by a team of qualified persons after each assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, observation, and interview the facility failed to evaluate and update the Care Plan for seven residents (#41, #60, #18, #83, #52, #55 and #57) of forty three residents reviewed.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included:<br><br>Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The facility provided evidence Care Plans were reviewed and revised for all residents to reflect the residents current status. The facility provided evidence of in-service for all staff and random audits to ensure compliance.<br><br>The facility will remain out of compliance at a "E" level until it provides an acceptable plan of correction to include continued monitoring to | {F 280} | transfer, offer rest periods, assist to the bathroom during rounds and as needed, bed in lowest position, a chair sensor pad. The care plan was audited by the Nursing Administration Staff to ensure that the plan of care had been updated to reflect the resident's current status on 2/29/12. The care plan was audited by the Nursing Administration Staff (Director of Nursing, Staffing Coordinator, and MDS Coordinator) to ensure that the plan of care had been updated to reflect the resident's current status on 2/29/12. The resident's care plan was reviewed by the Director of Nursing on 3/7/12 and evaluated for fall prevention strategies and deemed the intervention for constant supervision during toileting assessments that may not have been coded or updated correctly for the was inappropriate. After review of current interventions on | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2
FORM APPROV
OMB NO. 0938-0

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETIO DATE |
|---|---|---|---|---|
| {F 280} | Continued From page 12<br>and revised by a team of qualified persons after each assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, observation, and interview the facility failed to evaluate and update the Care Plan for seven residents (#41, #60, #18, #83, #52, #55 and #57) of forty three residents reviewed.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included:<br><br>Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The facility provided evidence Care Plans were reviewed and revised for all residents to reflect the residents current status. The facility provided evidence of in-service for all staff and random audits to ensure compliance.<br><br>The facility will remain out of compliance at a "E" level until it provides an acceptable plan of correction to include continued monitoring to | {F 280} | 3/7/12 by the Director of Nursing and further investigation of the incident (with intervention not to leave unattended) it was determined that the intervention was implemented before a full root cause analysis was conducted (the intervention was removed as of 2/24/12 interventions above). As of 3/22/12, current interventions, the resident remains on the FROG program, participates in restorative with ambulation "walk to dine program", low bed with mats, antiroll back brakes, the locking of wheel chair prior to transfer, offer rest periods, assist to the bathroom during rounds and as needed, further monitoring and interventions will continue to prevent falls. Care plan is current to resident's status and is updated per MDS and/or Charge Nurse on an ongoing bases and as needed with any new orders, interventions, or changes. | |



ldp

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2
FORM APPROV
OMB NO. 0938-03

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 280} | Continued From page 12<br>and revised by a team of qualified persons after each assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, observation, and interview the facility failed to evaluate and update the Care Plan for seven residents (#41, #60, #18, #83, #52, #55 and #57) of forty three residents reviewed.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included:<br><br>Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The facility provided evidence Care Plans were reviewed and revised for all residents to reflect the residents current status. The facility provided evidence of in-service for all staff and random audits to ensure compliance.<br><br>The facility will remain out of compliance at a "E" level until it provides an acceptable plan of correction to include continued monitoring to | {F 280} | **2.** A review of all residents MDS's and Care Plans was initiated on 2/28/12 and completed by 3/5/12 to identify other use of side rails/restraints. Ten residents were identified as needing changes made to a current or previous assessment (MDS) for the use of side rails, all of the ten were completed between 2/28/12 and 3/5/12. The care plans were audited by the Nursing Administration Staff for residents: **#41, 60, 18, 83, 52, 55, and 57** to ensure that the plan of care had been updated to reflect the resident's current status on 2/29/12. On 3/5/12 the Regional Nurse Consultant in-serviced the MDS Coordinator on documenting (communication) changes made to the resident's plan of care on the 24 hour report. The Nurse Aide Communication Sheet will also be updated when the plan of care changes by the MDS Coordinator(s). | |



67

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/
FORM APPRO
OMB NO. 0938-0

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETIO DATE |
|---|---|---|---|---|
| {F 280} | Continued From page 12<br>and revised by a team of qualified persons after each assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, observation, and interview the facility failed to evaluate and update the Care Plan for seven residents (#41, #60, #18, #83, #52, #55 and #57) of forty three residents reviewed.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included:<br><br>Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The facility provided evidence Care Plans were reviewed and revised for all residents to reflect the residents current status. The facility provided evidence of in-service for all staff and random audits to ensure compliance.<br><br>The facility will remain out of compliance at a "E" level until it provides an acceptable plan of correction to include continued monitoring to | {F 280} | 3. The Regional Nurse Consultant in-serviced the MDS Coordinator and the Staffing Coordinator/Back Up MDS Coordinator on 2/21/12 and 2/22/12 on the completion of accurate assessments and developing/revision of care plans to reflect the resident's current medical condition. Resident and families will be notified of scheduled care plan meetings by the MDS Coordinator prior to the residents next scheduled assessment and/or as needed to assist in developing a plan of care that meets the resident's personal/medical goals. The MDS Coordinator will utilize information provided in the morning Quality Assurance meeting, 24 hour report, resident's medical record, and communication from staff, residents, and/or families when completing resident assessments to ensure accuracy. On 2/23/12 the Interim MDS Coordinator was inserviced on accuracy when completing MDS's and the development and revision of care plans, along with recent survey deficiencies. | |



68

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/
FORM APPRO
OMB NO. 0938-

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETIC DATE |
|---|---|---|---|---|
| {F 280} | Continued From page 12<br>and revised by a team of qualified persons after each assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, observation, and interview the facility failed to evaluate and update the Care Plan for seven residents (#41, #60, #18, #83, #52, #55 and #57) of forty three residents reviewed.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included:<br><br>Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The facility provided evidence Care Plans were reviewed and revised for all residents to reflect the residents current status. The facility provided evidence of in-service for all staff and random audits to ensure compliance.<br><br>The facility will remain out of compliance at a "E" level until it provides an acceptable plan of correction to include continued monitoring to | {F 280} | 4. The Interdisciplinary Team(Administrator, Director of Nursing, and Assistant Director of Nursing, Maintenance Supervisor, Social Services/Admissions Director, MDS Coordinator, Food Service Supervisor, and Activity Director) will review all completed MDSs and Care Plans for accuracy, making revisions as needed daily (Monday-Friday) in the morning QA meeting. The Director or Assistant Director of Nursing will review MDSs and Care Plans to ensure compliance is met for the next 90 days; then weekly for 90 days if compliance has been maintained; then randomly thereafter. If at any point compliance is not met, the party will resume monitoring daily (Monday-Friday) until compliance is maintained. The Director or Assistant Director of Nursing will review findings related to the audits in the quarterly QA Committee.<br><br>**Completion date: 3/22/12** | |



69

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/201
FORM APPROVED
OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 280} | Continued From page 13<br>ensure the deficient practice does not recur and the facility's corrective measure could be reviewed and evaluated by the Quality Assurance Committee. | {F 280} | **F 281**<br><br>**483.20(k)(3)(i) Services Provided Meet Professional Standards** | |
| {F 281} SS=D | 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS<br><br>The services provided or arranged by the facility must meet professional standards of quality.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, and interview, the facility failed to follow physician's orders for one resident (#55) of forty-three residents reviewed.<br><br>The findings included:<br><br>Resident #55 was admitted to the facility on July 9, 2008, with diagnoses including Brain Syndrome with Presenile Brain Disease, Hypertension, Psychotic Mood Disorder, and Osteoarthrosis.<br><br>Medical record review of the Physician's Recapitulation Orders dated January 1, 2012, through January 31, 2012, revealed "...Clonidine (blood pressure medication) 0.1 mg (milligram) one tab (tablet) two times daily-hold if systolic (blood pressure) lower than 130..."<br><br>Medical record review of the Medication Administration Record dated January 1, 2012 through January 18, 2012, revealed Clonidine 0.1 mg was initialed as administered Janaury 1, 2012, through January 18, 2012 at 8:00 a.m. and | {F 281} | **SS=D**<br><br>**Requirement:**<br><br>The services provided or arranged by the facility must meet professional standard of quality.<br><br>**Corrective Action Plan:**<br><br>1. Resident #55 received medications as ordered by the physician beginning 2/16/12.<br><br>2. The Nursing Administration team audited the Medication Records for all residents completed on 3/19/12 to ensure residents were getting medications as ordered by the physician. All resident's MARs were found to be in compliance for receiving medications as ordered.<br><br>3. All licensed nursing staff were in-serviced by the Director of Nursing on 2/17/12, 2/29/12, and 3/15/12 on following physician orders when administering medications. | |



AD

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 281} | Continued From page 14<br>8:00 p.m.<br><br>Medical record review of the nursing notes revealed the following blood pressure reading obtained on the evening shift: January 1, 2012-120/40, January 3, 2012-128/54, January 4, 2012-122/70, January 6, 2012-126/68, January 7, 2012-124/72, January 9, 2012 no b/p , January 10, 2012- 120/70, January 11, 2012- 104/54, January 12, 2012-115/60, January 14, 2012-118/60, January 16, 2012-102/62, January 17, 2012-119/55, and January 18, 2012-118/65.<br><br>Interview with the Director of Nursing (DON) on February 16, 2012, at 8:25 a.m. in the small dining room, confirmed the Physician's Orders were not followed by administering the Clonidine when the systolic blood pressure was lower than 130. | {F 281} | 4. The Director of Nursing Services (DNS), or designee, will complete random audits of six (6) Medication Records to verify that medications are administered as ordered for six (6) consecutive weeks to ensure compliance is maintained.<br>Medication Audit findings will be discussed in morning QA meeting and quarterly QA Committee.<br><br>**Completion date: 3/22/12** | |
| {F 318} SS=D | 483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION<br><br>Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, observation, and interview the facility failed to prevent a decrease in Range of Motion for one resident (#52) reviewed for Range of Motion of forty three residents. | {F 318} | | |



71

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/[illegible]/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 281} | Continued From page 14<br>8:00 p.m.<br><br>Medical record review of the nursing notes revealed the following blood pressure reading obtained on the evening shift: January 1, 2012-120/40, January 3, 2012-128/54, January 4, 2012-122/70, January 6, 2012-126/68, January 7, 2012-124/72, January 9, 2012 no b/p , January 10, 2012- 120/70, January 11, 2012- 104/54, January 12, 2012-115/60, January 14, 2012-118/60, January 16, 2012-102/62, January 17, 2012-119/55, and January 18, 2012-118/65.<br><br>Interview with the Director of Nursing (DON) on February 16, 2012, at 8:25 a.m. in the small dining room, confirmed the Physician's Orders were not followed by administering the Clonidine when the systolic blood pressure was lower than 130. | {F 281} | | |
| {F 318} SS=D | 483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION<br><br>Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, observation, and interview the facility failed to prevent a decrease in Range of Motion for one resident (#52) reviewed for Range of Motion of forty three residents. | {F 318} | **F318**<br><br>**483.25(e)(2) Increase/Prevent Decrease In Range of Motion**<br><br>**SS=D**<br><br>**Requirement:**<br><br>Base on the comprehensive assessment of a resident the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of | |



72

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/201
FORM APPROVEI
OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 318} | Continued From page 15<br><br>The findings included:<br><br>Resident #52 was admitted to the facility on June 1, 2006, with diagnoses including Dementia, Mood Disorder, Depression, and Renal Insufficiency.<br><br>Medical record review of the Minimum Data Set (MDS) dated December 7, 2011, revealed "...moderately impaired for decision making...required extensive assist for bed mobility...no impairment in upper extremities...chair to prevent rising...bed rails used daily for restraint..."<br><br>Medical record review of a Physician Telephone Order dated December 2, 2011, revealed "...may use arm sling to keep arm on lap table to prevent injury..."<br><br>Medical record review of the Interdisciplinary Plan of Care last reviewed December 7, 2011, revealed "...may use arm immobilizer to help support R (right) arm on lap tray (to prevent injury)...lap table on W/C (wheel chair)...keep R arm on lap table when in W/C..."<br><br>Medical record review of the February 2012 Physician Recapitulation Orders revealed "...lap tray while up in W/C...may use sling to help support..."<br><br>Observation on February 8, 2012, at 12:50 p.m., on the 200 hallway, revealed the resident in a wheelchair, the lap tray in place, the shoulder immobilizer around the resident's chest and the right arm secured to the chest with a Velcro strap | {F 318} | motion and/or to prevent further decrease in range of motion.<br><br>**Corrective Action Plan:**<br><br>1.The MDS Coordinator completed a significant change assessment with Assessment Reference Date of 2/23/12 to reflect resident #52's current status. Therapy evaluated the resident on 2/28/12 with a plan for Restorative Nursing to treat for ROM.<br><br>2. The Nursing Administration team audited residents for a change in range of motion, through random rounds completed on 3/17/12 with no new residents identified has having a change in their ROM.<br><br>3.Staff was in-serviced by the Administrator and/or Director of Nursing on 2/17/12, 2/27/12, 2/29/12, and 3/15/12 on changes in resident status, not limited to: decrease in ROM, ambulation, and ADL's. | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 318} | Continued From page 16<br>on the immobilizer.<br><br>Observation on February 9, 2012, at 3:45 p.m., in the front lobby, revealed the resident in a wheelchair, leaning to the right side of the wheelchair, the lap tray in place, the shoulder immobilizer not in use, and the right arm hanging over the right arm rest of the wheelchair extending toward the floor (no immobilizer).<br><br>Observation on February 9, 2012, at 5:00 p.m., in the front lobby, revealed the resident in the wheelchair, the lap tray in place, the shoulder immobilizer around the resident's chest and the resident's bilateral wrists attached with a Velcro strap to the immobilizer (different application).<br><br>Observation on February 14, 2012, at 7:30 a.m., on the 200 hallway, revealed the resident in the wheelchair, the lap tray in place, and the shoulder immobilizer around the resident's chest and the right arm attached with a Velcro strap to the immobilizer. (different application)<br><br>Observation on February 14, 2012, at 10:50 a.m., in the front lobby, revealed the resident in the wheelchair, the lap tray in place, the shoulder immobilizer around the resident's chest, and the right and left arms attached with a Velcro strap to the immobilizer (different application).<br><br>Observation with the Nursing Home Administrator (NHA) on February 14, 2012, at 11:00 a.m., in the front lobby, revealed the resident in the wheelchair, the lap tray in place, the shoulder immobilizer around the resident's chest, and the right and left wrists attached with a Velcro strap to the immobilizer (different application). | {F 318} | 4.The DON or designee will monitor for compliance through random round audits for six (6) weeks, referring residents demonstrating a decline in ROM to the therapy department for screening.<br><br>**Completion date: 3/22/12** | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 318} | Continued From page 17<br><br>Interview with the NHA on February 14, 2012, at 11:05 a.m., in the front lobby, confirmed the shoulder immobilizer was used to keep the right arm only on the lap table and the shoulder immobilizer was not applied correctly.<br><br>Interview with Certified Occupational Therapy Assistant (COTA) #1 on February 14, 2012, at 1:10 p.m., in the small dining room, confirmed nursing service had applied a shoulder immobilizer on the resident and the immobilizer had not been evaluated or assessed by Physical Therapy or Occupational Therapy. Further interview confirmed "The resident has limited ROM (Range of Motion) this is a decline for this resident, I'm going to remove it."<br><br>Interview with Director of Nursing (DON) on February 15, 2012, at 1:21 p.m., in the Nurse's Station, confirmed no assessment for the use of the immobilizer had been completed; the immobilizer prevented the resident from moving the arm; the staff had not been in-serviced on how to apply the immobilizer and had not reveived any instructions or documentation for ROM exercises.<br><br>Interview with the MDS Coordinator on February 17, 2012, at 8:00 a.m., in the MDS Office, confirmed the Physical Therapy staff instructed the MDS staff on the functional limitations of the upper extremities(shoulder, elbow, wrist, arm) on the MDS dated December 7, 2011, and they coded according to the information provided by the Physical Therapy staff. Further interview confirmed the resident's last assessment had been completed on January 7, 2012, and | {F 318} | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/201
FORM APPROVE
OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 318} | Continued From page 18<br>Physical Therapy Staff had not provided any information for coding the functional limitations of the resident's upper extremities. Continued interview confirmed the facility started using an arm sling on December 2, 2011, and the shoulder immobilizer on February 4, 2012.<br><br>Interview with the COTA #2 on February 17, 2012, at 8:10 a.m., in the living room, confirmed the resident's left and right arms, and bilateral shoulders had a functional limitation in ROM in the bilateral arms and shoulders.<br><br>Interview with the DON on February 17, 2012, at 8:15 a.m., in the living room, confirmed the Comprehensive Assessment completed on January 7, 2012, assessed the resident with no functional limitation in ROM and the facility has no documentation or knowledge of a decline in ROM in the resident's medical record until February 14, 2012.<br><br>Interview by telephone with the Occupational Therapy Registered (OTR) on February 17, 2012, at 1:10 p.m., in the Staffing Coordinator's Office, confirmed ROM should be performed when an immobilizer is used to prevent a decrease in ROM, and schedule for how long the immobilizer is to be left in place.<br><br>Interview with the resident's Medical Doctor by telephone on February 21, 2012, at 9:12 a.m., confirmed the Medical Doctor visited the resident February 20, 2012, and the resident had a decrease in ROM and ROM exercises should have been performed by the facility to prevent a decline in the resident's condition. | {F 318} | | |
| {F 323} | 483.25(h) FREE OF ACCIDENT | {F 323} | | |



16

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 323} SS=E | Continued From page 19<br>HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, facility policy review, Guidance for Industry and FDA (Food and Drug Administration) Staff, observation, and interview, the facility failed to reduce or eliminate a siderail restraint after multiple falls from the bed with full side rails in use, for one resident (#41) of two residents reviewed, failed to identify the risk for side rail entrapment for two residents (#18, #60) of two residents of twenty-three residents reviewed for siderails, failed to assure safety devices were on and properly operating for two residents (#57, #94) two of two residents of ten residents reviewed for accidents, and failed to supervise to prevent falls for one resident (#55) of forty-three residents reviewed.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included: | {F 323} | **F 323**<br><br>**483.25 (h) Free of Accident**<br><br>**SS=E**<br><br>**Requirement:**<br><br>The facility will ensure that the resident environment remains free of facility hazards as possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>**Corrective Action:**<br><br>1. (a) Upon review of the Fall Risk Assessment on 2/6/12 completed by the licensed nurse the systematic review of risk factors indicated a risk score of 24 (high risk) for resident #41. Based on the risk factors from his Fall Risk Assessment it was determined that he was not a candidate for the use of side rails due to impaired judgment, incontinence, and history of falls from his bed. The side rails were removed on 2/6/12 by the Maintenance Director. The nursing administration staff communicated changes made to the resident's plan of care (removal of | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/20
FORM APPROVE
OMB NO. 0938-03

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 323} SS=E | Continued From page 19<br>HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, facility policy review, Guidance for Industry and FDA (Food and Drug Administration) Staff, observation, and interview, the facility failed to reduce or eliminate a siderail restraint after multiple falls from the bed with full side rails in use, for one resident (#41) of two residents reviewed, failed to identify the risk for side rail entrapment for two residents (#18, #60) of two residents of twenty-three residents reviewed for siderails, failed to assure safety devices were on and properly operating for two residents (#57, #94) two of two residents of ten residents reviewed for accidents, and failed to supervise to prevent falls for one resident (#55) of forty-three residents reviewed.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included: | {F 323} | side rails and low bed with one mat) to the direct caregivers on the Nurse Aide Communication Worksheet and the Care plans on 2/6/12. On 2/17/12 a telephone order was obtained by the charge nurse and the Director of Nursing to discontinue the resident's bed and chair alarm and use a sensor pressure pad for his bed and chair. The resident remains on a low bed with one mat at bedside after receiving a telephone order from the physician on 2/23/12. The resident's care plan was updated on 2/24/12 by the Interim MDS Coordinator to reflect the current orders and interventions (other interventions: involve in activities, slip resistant footwear, may place in the sight of staff when awake, rest periods as needed, family at bedside sessions throughout the day, get patient up when trying to get out of bed, offer snacks, attempt to keep resident dry or clean immediately after incontinent episode). The care plan was audited by the Nursing Administration Staff to ensure that the plan of care had been updated to reflect the resident's current status on 2/24/12. Resident was hospitalized | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/20
FORM APPROVE
OMB NO. 0938-03

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 323} SS=E | Continued From page 19<br>HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, facility policy review, Guidance for Industry and FDA (Food and Drug Administration) Staff, observation, and interview, the facility failed to reduce or eliminate a siderail restraint after multiple falls from the bed with full side rails in use, for one resident (#41) of two residents reviewed, failed to identify the risk for side rail entrapment for two residents (#18, #60) of two residents of twenty-three residents reviewed for siderails, failed to assure safety devices were on and properly operating for two residents (#57, #94) two of two residents of ten residents reviewed for accidents, and failed to supervise to prevent falls for one resident (#55) of forty-three residents reviewed.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included: | {F 323} | from 2/24/12 to 3/2/12, returning with a change in medical status. The Fall Risk Assessment updated on 3/5/12 by the Director of Nursing reflects that resident no longer attempts to self transfer, requiring assistance of 2 for transfers. The resident no longer requires constant supervision for the prevention of falls. He is on the FROG Program that provides closer observation from various staff members. Resident was transferred to the hospital again on 3/9/12 after visit by attending physician. MDS Coordinator completed a discharge assessment on 3/9/12. Resident was readmitted on 3/15/12 with admitting Charge Nurse completing Fall Risk Assessment and Evaluation for the Use of Side Rails with the recommendation to be that side rails were not indicated at that time. Resident's care plan was | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 323} SS=E | Continued From page 19<br>HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, facility policy review, Guidance for Industry and FDA (Food and Drug Administration) Staff, observation, and interview, the facility failed to reduce or eliminate a siderail restraint after multiple falls from the bed with full side rails in use, for one resident (#41) of two residents reviewed, failed to identify the risk for side rail entrapment for two residents (#18, #60) of two residents of twenty-three residents reviewed for siderails, failed to assure safety devices were on and properly operating for two residents (#57, #94) two of two residents of ten residents reviewed for accidents, and failed to supervise to prevent falls for one resident (#55) of forty-three residents reviewed.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included: | {F 323} | updated on 3/21/12 with a significant change assessment. Resident's care plan is updated per MDS and/or Charge Nurse on ongoing bases and as needed with any new orders, interventions, or changes.<br><br>(b) Resident #18 The side rails that were in place during the survey were immediately changed to full anti-entrapment rails on 2/6/12 by the Maintenance Director after receiving a physician's order. The measurements for the bed zones were obtained by the Maintenance Director on 2/6/12 using a standard tape measure with measurements. The Staffing Coordinator wrote a narrative note in the nurses notes on 2/6/12 describing the resident with limited functional status using the side rails as a restraint. A Physical Restraint Assessment was updated on 2/6/12 for the use of side rails. A Side Rail Assessment and Informed Consent was signed by the family on 2/13/12. On 2/20/12 the MDS Coordinator completed an Evaluation for use of Side Rails with a reduction in side rails from full (anti- | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 323} SS=E | Continued From page 19<br>HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, facility policy review, Guidance for Industry and FDA (Food and Drug Administration) Staff, observation, and interview, the facility failed to reduce or eliminate a siderail restraint after multiple falls from the bed with full side rails in use, for one resident (#41) of two residents reviewed, failed to identify the risk for side rail entrapment for two residents (#18, #60) of two residents of twenty-three residents reviewed for siderails, failed to assure safety devices were on and properly operating for two residents (#57, #94) two of two residents of ten residents reviewed for accidents, and failed to supervise to prevent falls for one resident (#55) of forty-three residents reviewed.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included: | {F 323} | entrapment) to ½ rails, the physician was notified and order was obtained for ½ rails. The measurements for the bed zones were obtained by the Maintenance Director on 2/20/12. On 2/23/12 the resident was evaluated again for side rail reduction by the Staffing Coordinator, the resident's side rails was eliminated and the resident was placed on a low bed with mats. The Physical Restraint Assessment was completed on 2/28/12 by the Staffing Coordinator for the elimination of side rails and the use of a low bed with mats after receiving a physician's order. The care plan was audited by the Nursing Administration Staff to ensure that the plan of care had been updated to reflect the resident's current status on 2/29/12. On 3/5/12 resident rolled out of bed with a small laceration to upper lip with intervention to check placement of furniture and remove if in pathway. Keep room free of clutter for safety. Bowel and bladder program to determine habit time, and FROG Program. Care plan was updated to reflect new interventions for 3/5, 3/13 | |



81

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/20
FORM APPROVE
OMB NO. 0938-03

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 323} SS=E | Continued From page 19<br>HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, facility policy review, Guidance for Industry and FDA (Food and Drug Administration) Staff, observation, and interview, the facility failed to reduce or eliminate a siderail restraint after multiple falls from the bed with full side rails in use, for one resident (#41) of two residents reviewed, failed to identify the risk for side rail entrapment for two residents (#18, #60) of two residents of twenty-three residents reviewed for siderails, failed to assure safety devices were on and properly operating for two residents (#57, #94) two of two residents of ten residents reviewed for accidents, and failed to supervise to prevent falls for one resident (#55) of forty-three residents reviewed.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included: | {F 323} | resident was found in room 129 bathroom with one shoe on. Resident had gotten up from her wheel chair in another resident's room, with interventions for proper footwear (nonskid) replace footwear when resident removes as allows with physical therapy to screen. On 3/15, further intervention was added to get up after breakfast as desires after further investigation of fall on 3/13. Fall on 3/17 where resident rolled from the bed in her sleep, bed was in lowest position with mats on both sides, no injury noted, intervention to add pool noodles to define perimeter of the bed with all above interventions added to the care plan as implemented. Resident's care plan is updated per MDS and/or Charge Nurse on an ongoing bases and as needed with any new orders, interventions, or changes. | |



82

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 323} SS=E | Continued From page 19<br>HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, facility policy review, Guidance for Industry and FDA (Food and Drug Administration) Staff, observation, and interview, the facility failed to reduce or eliminate a siderail restraint after multiple falls from the bed with full side rails in use, for one resident (#41) of two residents reviewed, failed to identify the risk for side rail entrapment for two residents (#18, #60) of two residents of twenty-three residents reviewed for siderails, failed to assure safety devices were on and properly operating for two residents (#57, #94) two of two residents of ten residents reviewed for accidents, and failed to supervise to prevent falls for one resident (#55) of forty-three residents reviewed.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included: | {F 323} | (c) Resident # 60 The side rails that were in place during the survey were immediately changed to full anti-entrapment rails (prior to the exit of the surveyors) on 2/6/12 by the Maintenance Director. The measurements for the bed zones were obtained by the Maintenance Director on 2/6/12 using a standard tape measure. The Side Rail Assessment and Informed Consent Form (one form) was later completed by the Staffing Coordinator on 2/6/12 for the use of side rails with a reduction from full side rails to ½ side rails after receiving a physician's order for the use of ½ rails by the Staffing Coordinator (after the exit of the surveyors for the evening) that were changed out per the Maintenance Director. The bed zone measurements were obtained by the Maintenance Director on 2/6/12. A Pre-Restraint Assessment was completed on 2/21/12 by the Staffing | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/
FORM APPRO
OMB NO. 0938-0

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETIO DATE |
|---|---|---|---|---|
| {F 323} SS=E | Continued From page 19<br>HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, facility policy review, Guidance for Industry and FDA (Food and Drug Administration) Staff, observation, and interview, the facility failed to reduce or eliminate a siderail restraint after multiple falls from the bed with full side rails in use, for one resident (#41) of two residents reviewed, failed to identify the risk for side rail entrapment for two residents (#18, #60) of two residents of twenty-three residents reviewed for siderails, failed to assure safety devices were on and properly operating for two residents (#57, #94) two of two residents of ten residents reviewed for accidents, and failed to supervise to prevent falls for one resident (#55) of forty-three residents reviewed.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included: | {F 323} | Coordinator that indicated side rails being used as a restraint and assisting the resident. Resident was transferred to hospital on 2/26/12. The Interim MDS Coordinator completed a Discharge Assessment on 2/29/12 which reflected the use of side rails as a restraint (as ½ rails were used until 2/23/12 during the 7 day look back period). The resident was reassessed upon return to the facility on 3/12/12 by the admitting Charge Nurse who completed an Evaluation for the use of Side Rails and a Fall Risk Assessment with the recommendation for no side rails indicated at this time. The MDS Coordinator completed a 5 day Readmission Assessment on 3/22/12. (A 14 day Assessment was completed on 3/29/12). Resident's care plan is updated per MDS and/or Charge Nurse on an ongoing base and as needed with any new orders, interventions, or changes. | |



84

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2
FORM APPROV
OMB NO. 0938-03

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 323} SS=E | Continued From page 19<br>HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, facility policy review, Guidance for Industry and FDA (Food and Drug Administration) Staff, observation, and interview, the facility failed to reduce or eliminate a siderail restraint after multiple falls from the bed with full side rails in use, for one resident (#41) of two residents reviewed, failed to identify the risk for side rail entrapment for two residents (#18, #60) of two residents of twenty-three residents reviewed for siderails, failed to assure safety devices were on and properly operating for two residents (#57, #94) two of two residents of ten residents reviewed for accidents, and failed to supervise to prevent falls for one resident (#55) of forty-three residents reviewed.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included: | {F 323} | (d) Resident # 57 A telephone order was received from the resident's physician for the use of ½ side rails on *2/10/12*. The resident was assessed on 2/20/12 using the Evaluation for use of Side Rails (for the evaluation of side rail use) indicating the use of ½ side rails by the Staffing Coordinator. A Pre-Restraint Assessment was completed on 2/21/12 by the Director of Nursing that indicated side rails are used as a restraint. On 2/24/12 another Evaluation for the use of Side Rail was completed by the Staffing Coordinator indicating the elimination of ½ side rails (no side rails are in place at this time). As of 2/24/12 the resident's current interventions include: the locking of wheel chair prior to transfer, offer rest periods, assist to the bathroom during rounds and as needed, bed in lowest position, a chair sensor pad. The care plan was audited by the Nursing Administration Staff to ensure that the plan of care had been updated to reflect the resident's current status on 2/29/12. The care plan was audited by the Nursing Administration Staff to ensure that the plan of care had been updated to | |



85

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2
FORM APPROV
OMB NO. 0938-03

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 323} SS=E | Continued From page 19<br>HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, facility policy review, Guidance for Industry and FDA (Food and Drug Administration) Staff, observation, and interview, the facility failed to reduce or eliminate a siderail restraint after multiple falls from the bed with full side rails in use, for one resident (#41) of two residents reviewed, failed to identify the risk for side rail entrapment for two residents (#18, #60) of two residents of twenty-three residents reviewed for siderails, failed to assure safety devices were on and properly operating for two residents (#57, #94) two of two residents of ten residents reviewed for accidents, and failed to supervise to prevent falls for one resident (#55) of forty-three residents reviewed.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included: | {F 323} | reflect the resident's current status on 2/29/12. The resident's care plan was reviewed by the Director of Nursing on 3/7/12 and evaluated for fall prevention strategies and deemed the intervention for constant supervision during toileting was inappropriate. After review of current interventions on 3/7/12 by the Director of Nursing and further investigation of the incident (with intervention not to leave unattended) it was determined that the intervention was implemented before a full root cause analysis was conducted (the intervention was removed as of 2/24/12 interventions above). As of 3/22/12, current interventions, the resident remains on the FROG program, participates in restorative with ambulation "walk to dine program", low bed with mats, antiroll back brakes, the locking of wheel chair prior to transfer, offer rest periods, assist to the bathroom during rounds and as needed, further monitoring and interventions will continue to prevent falls. Resident's care plan is current and updated | |



86

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 323} SS=E | Continued From page 19<br>HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, facility policy review, Guidance for Industry and FDA (Food and Drug Administration) Staff, observation, and interview, the facility failed to reduce or eliminate a siderail restraint after multiple falls from the bed with full side rails in use, for one resident (#41) of two residents reviewed, failed to identify the risk for side rail entrapment for two residents (#18, #60) of two residents of twenty-three residents reviewed for siderails, failed to assure safety devices were on and properly operating for two residents (#57, #94) two of two residents of ten residents reviewed for accidents, and failed to supervise to prevent falls for one resident (#55) of forty-three residents reviewed.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included: | {F 323} | per MDS and/or Charge Nurse on an ongoing bases and as needed with any new orders, interventions, or changes.<br><br>(e) Resident #94 The facility staff provides supervision through routine rounds (minimum of every 2 hours), during care delivery, activities, and meals. The chair sensor pad was discontinued on 3/5/12 by the Director of Nursing after reviewing current interventions. After placing the resident in the correct wheel chair with anti-lock brakes on 2/6/12 the resident was identified not to be at risk for falls of a similar incident (wheel chair rolling back). The resident utilizes the wheel chair to push himself into a standing position; the anti-lock brakes prevent the chair from rolling providing the resident with stability. An identifier with the resident's name was attached to the wheel chair on 2/29/12. The resident's care plan was reviewed and updated by the Director of Nursing on 2/29/12 to reflect the resident's current status. After review of current interventions on 3/7/12 by the Director of Nursing | |



87

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 323} SS=E | Continued From page 19<br>HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, facility policy review, Guidance for Industry and FDA (Food and Drug Administration) Staff, observation, and interview, the facility failed to reduce or eliminate a siderail restraint after multiple falls from the bed with full side rails in use, for one resident (#41) of two residents reviewed, failed to identify the risk for side rail entrapment for two residents (#18, #60) of two residents of twenty-three residents reviewed for siderails, failed to assure safety devices were on and properly operating for two residents (#57, #94) two of two residents of ten residents reviewed for accidents, and failed to supervise to prevent falls for one resident (#55) of forty-three residents reviewed.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included: | {F 323} | (f) Resident #55 care plan was reviewed and modified on 2/14/12 by the MDS Coordinator and reflected the resident's current status. No further assessments or care plan updates could be completed due to the resident expiring on 2/16/12.<br><br>2. (a) The Fall Risk Assessment for all residents (utilizing the current assessment) was reviewed and verified to be correct by the Nursing Administration Team on 2/28/12. The nursing administration team reviewed and revised the care plans for residents that scored at high risk for falls ensuring that fall preventative interventions have been implemented on those as of 2/28/12 through 3/5/12. As of 3/5/2012, 11 residents scored High (20 or above) on the Fall Risk Assessment.<br>(b) The charge nurse or a member of nursing administration will complete a Fall Risk Assessment upon Admission/Readmission, significant change, after a fall, and at minimum of quarterly. The charge nurse will implement a new or modified | |



88

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 323} SS=E | Continued From page 19<br>HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, facility policy review, Guidance for Industry and FDA (Food and Drug Administration) Staff, observation, and interview, the facility failed to reduce or eliminate a siderail restraint after multiple falls from the bed with full side rails in use, for one resident (#41) of two residents reviewed, failed to identify the risk for side rail entrapment for two residents (#18, #60) of two residents of twenty-three residents reviewed for siderails, failed to assure safety devices were on and properly operating for two residents (#57, #94) two of two residents of ten residents reviewed for accidents, and failed to supervise to prevent falls for one resident (#55) of forty-three residents reviewed.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included: | {F 323} | intervention (updating the Nurse Aide Communication Sheet, 24 hour report sheet, and care plan) to prevent further falls. The Director of Nursing or Assistant Director of Nursing will in-service staff on any modifications made regarding fall interventions after the morning QA Meeting (where occurrences/falls are discussed). A Fall Focus Committee consisting of the Interdisciplinary Team (not limited to: Director/Assistant Director of Nursing, MDS Coordinator, Social Services, Activity Director) is conducted monthly, and or as needed to recap occurrences that have occurred during the month and evaluate the success of implemented interventions (occurrences are discussed/reviewed daily (Monday-Friday) in the QA meeting). A review of all residents MDS's and Care Plans was initiated on 2/28/12 to identify other assessments or Care Plans that may not have been coded or updated correctly for the use of side rails/restraints. Resident's that are identified as being out of | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/20
FORM APPROVE
OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 323} SS=E | Continued From page 19<br>HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, facility policy review, Guidance for Industry and FDA (Food and Drug Administration) Staff, observation, and interview, the facility failed to reduce or eliminate a siderail restraint after multiple falls from the bed with full side rails in use, for one resident (#41) of two residents reviewed, failed to identify the risk for side rail entrapment for two residents (#18, #60) of two residents of twenty-three residents reviewed for siderails, failed to assure safety devices were on and properly operating for two residents (#57, #94) two of two residents of ten residents reviewed for accidents, and failed to supervise to prevent falls for one resident (#55) of forty-three residents reviewed.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included: | {F 323} | compliance will have a modification/significant change and/or revision to the Care Plan to be completed to reflect the resident's current status by the MDS Coordinator(s). The Nursing Administrative staff conducted walking rounds to compare the resident's current interventions (list not all inclusive: to include safety devices such as: alarms, chairs used or mobility, beds, mats, side rails, walkers) against the care plan to ensure that no other resident would be affected by this deficient practice on 2/28/12. The individual resident's need for supervision and current fall preventative interventions was updated as needed on to the Nurse Aide Communication Sheet.<br>3. (a) The nursing administration staff communicated changes to resident status such as bed changes, modification of side rails, or modification to restraint usage to the direct care givers (CNA's , licensed nurses, and therapist) on the Nurse Aide Communication Worksheet, Care Plans, and/or the 24 hour report book as of 2/28/12. The Assistant | |



90

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2
FORM APPROV
OMB NO. 0938-03

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 323} SS=E | Continued From page 19<br>HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, facility policy review, Guidance for Industry and FDA (Food and Drug Administration) Staff, observation, and interview, the facility failed to reduce or eliminate a siderail restraint after multiple falls from the bed with full side rails in use, for one resident (#41) of two residents reviewed, failed to identify the risk for side rail entrapment for two residents (#18, #60) of two residents of twenty-three residents reviewed for siderails, failed to assure safety devices were on and properly operating for two residents (#57, #94) two of two residents of ten residents reviewed for accidents, and failed to supervise to prevent falls for one resident (#55) of forty-three residents reviewed.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included: | {F 323} | Director of Nursing will post an updated list for residents with side rails in the front of the CNA assignment book as changes are made to the resident's current side rail status beginning 2/29/12. All residents using wheel chairs and geri chairs will have resident specific identifiers added to their chair by 3/1/12 by the Maintenance Assistant.<br><br>(b) Upon admission/readmission, residents will be assessed using the Evaluation for the use of Side Rail Assessment tool by the Charge Nurse or Nursing Administration for the appropriateness of side rails (using the least restrictive device). Further side rail evaluations will be reviewed with significant changes, at a minimum of quarterly and/or as needed by the charge nurse, MDS Coordinator and/or nursing administration. The least restrictive side rail will be used as a restraint only after all other alternatives (list not all inclusive: low bed with mats, bed in lowest position, pool noodles, | |



91

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/201
FORM APPROVE
OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 323} SS=E | Continued From page 19<br>HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, facility policy review, Guidance for Industry and FDA (Food and Drug Administration) Staff, observation, and interview, the facility failed to reduce or eliminate a siderail restraint after multiple falls from the bed with full side rails in use, for one resident (#41) of two residents reviewed, failed to identify the risk for side rail entrapment for two residents (#18, #60) of two residents of twenty-three residents reviewed for siderails, failed to assure safety devices were on and properly operating for two residents (#57, #94) two of two residents of ten residents reviewed for accidents, and failed to supervise to prevent falls for one resident (#55) of forty-three residents reviewed.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included: | {F 323} | wing mattresses, toileting schedules, activities, non-skid surfaces, modification of room location, observe behavior/wake patterns, assistive devices, reclining /rocker chairs, drop seats, tilt back chairs, medication review/adjustment, identification markers (FROG program- process identified later in the F 323 document), family visits) have been attempted without success. A Pre-restraint Assessment will be completed by the charge nurse or by a member of the Nursing Administration Staff prior to the use of a restraint. The Pre-Restraint Assessment will guide the nurse in making a decision if a restraint is recommended and offer alternative ideas (on the back of form) that can reduce the risk of injuries associate with falls/restraints for residents at high risk for falls without the use of a physical device. An alternative intervention can be attempted based on the individual resident's Pre-Restraint Assessment in no specific order. The Pre-restraint Assessment can | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/201
FORM APPROVE
OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 323} SS=E | Continued From page 19<br>HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, facility policy review, Guidance for Industry and FDA (Food and Drug Administration) Staff, observation, and interview, the facility failed to reduce or eliminate a siderail restraint after multiple falls from the bed with full side rails in use, for one resident (#41) of two residents reviewed, failed to identify the risk for side rail entrapment for two residents (#18, #60) of two residents of twenty-three residents reviewed for siderails, failed to assure safety devices were on and properly operating for two residents (#57, #94) two of two residents of ten residents reviewed for accidents, and failed to supervise to prevent falls for one resident (#55) of forty-three residents reviewed.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included: | {F 323} | be updated on an ongoing basis for interventions that have been attempted without success with the date written to the side of the intervention attempted. If a restraint is recommended, the resident will be assessed at a minimum of quarterly and/or as needed to determine if the restraint is still appropriate or if a reduction can be attempted. After the completion of an Evaluation for the use of Side Rail assessment and/or a Pre-Restraint Assessment, the Maintenance Director or Maintenance Assistant will be notified by the nurse of the least restrictive side rails needed to achieve the resident's highest physical functioning status. The Maintenance Director or Assistant will place the appropriate side rails on the resident's bed measuring each Zone using a standard tape measure, documenting his findings on the Side Rail Log. The Maintenance Director demonstrated the bed | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 323} SS=E | Continued From page 19<br>HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, facility policy review, Guidance for Industry and FDA (Food and Drug Administration) Staff, observation, and interview, the facility failed to reduce or eliminate a siderail restraint after multiple falls from the bed with full side rails in use, for one resident (#41) of two residents reviewed, failed to identify the risk for side rail entrapment for two residents (#18, #60) of two residents of twenty-three residents reviewed for siderails, failed to assure safety devices were on and properly operating for two residents (#57, #94) two of two residents of ten residents reviewed for accidents, and failed to supervise to prevent falls for one resident (#55) of forty-three residents reviewed.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included: | {F 323} | zone measuring process to each Charge Nurse and a return demonstration was performed by each charge nurse (2/7/12 – 3/1/12), allowing the nurse the ability to measure side rails in the absence of the Maintenance Director or Assistant. If a resident's condition changes that may require a change in the side rail type, the nurse must first complete a new Evaluation for the use of Side Rail Assessment, notify the physician to obtain new orders, then notify the Maintenance Director and/or Assistant for placement. Side rails will be measured each time there is a change in the side rail type, quarterly, and as needed by the Maintenance Director or Assistant.<br><br>(c) In-services were conducted on 2/6/12, 2/7/12, 2/8/12, 2/9/12, 2/13/12, 2/17/12, and 2/24/12 for facility staff by the Administrator, Maintenance Director and/or the Director of Nursing regarding but not limited to: the completion of Side | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2
FORM APPROVE
OMB NO. 0938-03

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 323} SS=E | Continued From page 19<br>HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, facility policy review, Guidance for Industry and FDA (Food and Drug Administration) Staff, observation, and interview, the facility failed to reduce or eliminate a siderail restraint after multiple falls from the bed with full side rails in use, for one resident (#41) of two residents reviewed, failed to identify the risk for side rail entrapment for two residents (#18, #60) of two residents of twenty-three residents reviewed for siderails, failed to assure safety devices were on and properly operating for two residents (#57, #94) two of two residents of ten residents reviewed for accidents, and failed to supervise to prevent falls for one resident (#55) of forty-three residents reviewed.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included: | {F 323} | Rail Assessment and Informed Consent, Evaluation for the use of Side Rails to be completed prior to the use of side rails. Pre-Restraint Assessment, Physical Restraint Assessment (when, on whom, why, and how the assessment is to be completed), the risk of entrapment associated with side rail use and how to obtain bed zone measurements per the FDA "best practice" standards. All staff was again in serviced regarding the above by the Administrator, Maintenance Director and/or the Director of Nursing on 2/29/12. All staff including new hires, contracted staff (performing direct care) and staff on leave of absence will be in serviced by the Administrator, Maintenance Director and/or the Director of Nursing regarding but not limited to: the completion of Side Rail Assessment and Informed Consent, Evaluation for the use of Side Rails to be completed prior to the use of side rails, Pre-Restraint Assessment, Physical Restraint Assessment (when, on whom, why, and how the assessment is to be completed), the risk of entrapment associated with side rail use and how to obtain bed | |



95

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2
FORM APPROV
OMB NO. 0938-0

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 323} SS=E | Continued From page 19<br>HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, facility policy review, Guidance for Industry and FDA (Food and Drug Administration) Staff, observation, and interview, the facility failed to reduce or eliminate a siderail restraint after multiple falls from the bed with full side rails in use, for one resident (#41) of two residents reviewed, failed to identify the risk for side rail entrapment for two residents (#18, #60) of two residents of twenty-three residents reviewed for siderails, failed to assure safety devices were on and properly operating for two residents (#57, #94) two of two residents of ten residents reviewed for accidents, and failed to supervise to prevent falls for one resident (#55) of forty-three residents reviewed.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included: | {F 323} | zone measurements per the FDA "best practice" standards prior to working their scheduled shift. Another in-service was presented by the Administrator on 3/15/12 to review survey findings and the plan of correction.<br><br>(d) The Director or Assistant Director of Nursing will provide ongoing education on the importance and implementation of interventions to prevent falls. The facility began working with Q-Source (October, 2011) on a restraint reduction collaborative, that also provides ideas to assist with reducing falls. The Administrator contacted the Q-Source representative who registered the Director of Nursing, Assistant Director of Nursing, Activity Director and MDS Coordinator for a ***Physical Restraint & Pressure Ulcer Regional Collaborative Learning Session*** on April10, 2012. On 3/5/12 the Director of Nursing revised the FROG (Fall Reduction | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 323} SS=E | Continued From page 19<br>HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, facility policy review, Guidance for Industry and FDA (Food and Drug Administration) Staff, observation, and interview, the facility failed to reduce or eliminate a siderail restraint after multiple falls from the bed with full side rails in use, for one resident (#41) of two residents reviewed, failed to identify the risk for side rail entrapment for two residents (#18, #60) of two residents of twenty-three residents reviewed for siderails, failed to assure safety devices were on and properly operating for two residents (#57, #94) two of two residents of ten residents reviewed for accidents, and failed to supervise to prevent falls for one resident (#55) of forty-three residents reviewed.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included: | {F 323} | Our Goal) Program to increase the level of supervision of residents identified as being at risk by involving all facility staff.<br>The Director of Nursing conducted an in-service on 3/5/12 to alert the facility staff on the revised FROG program. In-services were completed by 3/22/12 for the FROG program to notify all staff members of the revision. This process will also be added to the orientation program. Upon admission the resident will be placed on the FROG Program (a frog identifying marker to alert staff members that the resident is at risk for falls) for 30 days, at the end of the 30 day period the resident will be reviewed in the Fall Focus Committee consisting of the Interdisciplinary Team (not limited to: Director/Assistant Director of Nursing, MDS Coordinator, Social Services, Activity Director). If the resident has been free from falls for 30 days, the resident will be removed | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 323} SS=E | Continued From page 19<br>HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, facility policy review, Guidance for Industry and FDA (Food and Drug Administration) Staff, observation, and interview, the facility failed to reduce or eliminate a siderail restraint after multiple falls from the bed with full side rails in use, for one resident (#41) of two residents reviewed, failed to identify the risk for side rail entrapment for two residents (#18, #60) of two residents of twenty-three residents reviewed for siderails, failed to assure safety devices were on and properly operating for two residents (#57, #94) two of two residents of ten residents reviewed for accidents, and failed to supervise to prevent falls for one resident (#55) of forty-three residents reviewed.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included: | {F 323} | from the program. If the resident has experienced a fall in 30 days of the initiation of the program, the resident will continue on the program for 30 days (the process continues until the resident has been free from falls for 30 days). The findings will be documented in the resident's chart by a member of the Nursing Administration Staff and communicated to the staff via the Care Plan, Nurse Aide Communication Sheet, and the 24 hour report.<br><br>4. (a) The Maintenance Director or Assistant will bring the Side Rail Log to the morning Quality Assurance meeting to discuss any findings related to side rail measurements. The Administrator or Director of Nursing will review the Side Rail Log daily (Monday-Friday) to ensure the document is completed as needed to reflect the resident's current side rail measurements for the next 90 days; then weekly for 90 days if compliance has been | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 323} SS=E | Continued From page 19<br>HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, facility policy review, Guidance for Industry and FDA (Food and Drug Administration) Staff, observation, and interview, the facility failed to reduce or eliminate a siderail restraint after multiple falls from the bed with full side rails in use, for one resident (#41) of two residents reviewed, failed to identify the risk for side rail entrapment for two residents (#18, #60) of two residents of twenty-three residents reviewed for siderails, failed to assure safety devices were on and properly operating for two residents (#57, #94) two of two residents of ten residents reviewed for accidents, and failed to supervise to prevent falls for one resident (#55) of forty-three residents reviewed.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included: | {F 323} | maintained; then randomly thereafter. If at any point compliance is not met, the party will resume monitoring daily (Monday-Friday) until compliance is maintained.<br><br>(b) The Director or Assistant Director of Nursing will review occurrences daily (Monday-Friday) in the morning Quality Assurance meeting. The Director or Assistant Director of Nursing will review all documents (list not all inclusive: Evaluation for the use of Side Rails, Pre-Restraint, Physical Restraint Assessment, Care Plans, Nurse Event Note Investigation, Nurse Aide Communication Sheet, and telephone orders) to ensure forms are completed as needed and that interventions have been implemented and updated on the resident's care plan for the next 90 days; then weekly for 90 days if compliance has been maintained; then randomly thereafter. If at any point | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 323} SS=E | Continued From page 19<br>HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, facility policy review, Guidance for Industry and FDA (Food and Drug Administration) Staff, observation, and interview, the facility failed to reduce or eliminate a siderail restraint after multiple falls from the bed with full side rails in use, for one resident (#41) of two residents reviewed, failed to identify the risk for side rail entrapment for two residents (#18, #60) of two residents of twenty-three residents reviewed for siderails, failed to assure safety devices were on and properly operating for two residents (#57, #94) two of two residents of ten residents reviewed for accidents, and failed to supervise to prevent falls for one resident (#55) of forty-three residents reviewed.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included: | {F 323} | compliance is not met, the party (the Director or Assistant Director of Nursing) will resume monitoring daily (Monday-Friday) until compliance is maintained. The Director or Assistant Director of Nursing will review findings related to the audits in the quarterly QA Committee.<br><br>**Completion date: 3/22/12** | |



18D

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 323} | Continued From page 20<br><br>Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The facility provided evidence of conducting side rail and fall risk assessments for all residents, with removal of side rails when indicated, and evidence bed zone measurements were obtained to reduce or eliminate entrapment risk. The facility provided evidence of in-service for all staff and random audits to ensure compliance.<br><br>The facility will remain out of compliance at a "E" level until it provides an acceptable plan of correction to include continued monitoring to ensure the deficient practice does not recur and the facility's corrective measure could be reviewed and evaluated by the Quality Assurance Committee. | {F 323} | | |
| {F 371} SS=F | 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br><br>The facility must -<br>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br>(2) Store, prepare, distribute and serve food under sanitary conditions | {F 371} | **F 371**<br><br>**483.35(i) Food Procure Store/Prepare/Serve-Sanitary**<br><br>**SS=F**<br><br>**Requirement:**<br><br>The facility must: (1) Procure food from sources approved or considered satisfactory by Federal, State o local authorities; and (2) store, prepare, distribute and serve food under sanitary conditions. | |
| | This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview, the facility | | | |



101

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 371} | Continued From page 21<br>failed to maintain safe food temperatures in the dietary department.<br><br>The findings included:<br><br>Observation and interview on February 7, 2012, at 12:01 p.m., with the Regional Dietary Manager, in the dietary department, revealed three metal food carts with food trays containing eleven eight ounce glasses of milk. The temperature of one labeled "skim" was fifty degrees and one glass labeled "N" (nectar thick) was fifty three degrees. Interview at this time with the Regional Dietary Manager confirmed the safe temperature is forty one degrees or lower and the milk was at an unsafe temperature and available for resident use.<br><br>Observation and interview on February 7, 2012, at 12:06 p.m., in the Dining Room, with the Regional Dietary Manager, revealed a metal cart with two plastic pitchers of milk, the first pitcher was one half full at forty eight degrees, and the second pitcher was one fourth full at forty seven degrees. Interview at this time with the Regional Dietary Manager confirmed the safe temperature is forty one degrees or lower and the milk was at an unsafe temperature and was currently being served to the residents. | {F 371} | **Corrective Action Plan:**<br><br>1. Beverages are now being prepared and served at safe temperatures.<br><br>2. The Food Service Supervisor tested the temperature of milk products during beverage preparation on 3/15/12 & 3/19/12 with temperatures remaining in correct range.<br><br>3. Dietary staff was in-serviced on 2/7/12 and 3/15/12 by the Food Service Supervisor on the appropriate temperature for beverage products.<br><br>4. The Food Service Supervisor or designee will perform random audits during meals of prepared beverages to ensure appropriate temperatures are maintained for six (6) weeks. Findings will be discussed in the morning QA meeting.<br><br>**Completion date: 3/22/12** | |
| {F 406} SS=D | 483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES<br><br>If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility | {F 406} | | |

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 406} | Continued From page 22<br>must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, observation, and interview, the facility failed to provide timely speech therapy services for one (#38) of forty-three residents reviewed.<br><br>The findings included:<br><br>Resident #38 was admiited to the facility on January 10, 2012, with diagnoses including History of Stroke with Right Leg Weakness, Multiple Sclerosis, End Stage Dementia, Hypertension, History of Anxiety, and History of Depression.<br><br>Medical record review of the Physician's Admission Orders dated January 10, 2012, revealed the resident was to receive a Regular/Puree diet.<br><br>Medical record review of a physician's order dated February 1, 2012, revealed "Speech eval (evaluation) for diet upgrade."<br><br>Medical record review of the Plan of Treatment for Outpatient Rehabilitation dated February 5, 2012, revealed "...Pt (patient) will tolerate LRD (least restrictive diet) with upgrade trial with SLP (Speech Language Pathologist) without overt s/s (signs/symptoms) aspiration & intake 50%+ (plus)..." | {F 406} | **F406**<br><br>**483.45 (a) Provide/Obtain Specialized Rehab Services**<br><br>**SS=D**<br><br>**Requirement:**<br><br>If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services, or obtain the required services from an outside resource from a provider of specialized rehabilitative services.<br><br>**Corrective Action Plan:**<br><br>1. The Speech Language Pathologist evaluated Resident #38 on 2/5/12 and the resident is currently receiving diet as ordered. | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/20
FORM APPROVE
OMB NO. 0938-03

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 406} | Continued From page 22<br>must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, observation, and interview, the facility failed to provide timely speech therapy services for one (#38) of forty-three residents reviewed.<br><br>The findings included:<br><br>Resident #38 was admiited to the facility on January 10, 2012, with diagnoses including History of Stroke with Right Leg Weakness, Multiple Sclerosis, End Stage Dementia, Hypertension, History of Anxiety, and History of Depression.<br><br>Medical record review of the Physician's Admission Orders dated January 10, 2012, revealed the resident was to receive a Regular/Puree diet.<br><br>Medical record review of a physician's order dated February 1, 2012, revealed "Speech eval (evaluation) for diet upgrade."<br><br>Medical record review of the Plan of Treatment for Outpatient Rehabilitation dated February 5, 2012, revealed "...Pt (patient) will tolerate LRD (least restrictive diet) with upgrade trial with SLP (Speech Language Pathologist) without overt s/s (signs/symptoms) aspiration & intake 50%+ (plus)..." | {F 406} | 2. The Speech Pathologist audited telephone orders on 3/9/12 to determine if other residents were affected with no other issues noted.<br><br>3. The therapy department was in-serviced on 2/29/12 by the Administrator and on 3/9/12 by the Regional Rehab Manager on the processing therapy referrals.<br><br>4. The Program Manager or designee will conduct random audits of two (2) patients per week for six (6) weeks to ensure compliance is maintained. Findings will be discussed in the morning QA meeting.<br><br>**Completion date: 3/22/12** | |



104

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 406} | Continued From page 23<br><br>Medical record review of a physician's order dated February 10, 2012, revealed the diet texture was changed to dysphagia (difficult chewing) ground.<br><br>Observation on February 13, 2012, at 12:40 p.m., revealed the SLP feeding the resident a dysphagia mechanical diet, of chicken with gravy, potatoes, vegetables, biscuit, and prune cake.<br><br>Interview on February 13, 2012, at 12:55 p.m., with the SLP, in the small dining room, revealed orders for speech evaluations were to be completed within forty-eight hours, and confimed the delay in completing the speech evaluation ordered on February 1, 2012, until February 5, 2012. | {F 406} | | |
| {F 431} SS=E | 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS<br><br>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br><br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>In accordance with State and Federal laws, the | {F 431} | **F431**<br><br>**483.60 (b), (d), (e) Drug Records, Labels/Store Drugs & Biological**<br><br>**SS=E**<br><br>**Requirement:**<br><br>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are | |



105

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | COMPLETION DATE |
|---|---|---|---|---|
| {F 431} | Continued From page 24<br>facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, review of facility policy, and interview, the facility failed to ensure narcotics were reconciled and failed to ensure expired medications were discarded in one of one medication room and two of three medication carts.<br><br>The findings included:<br><br>Observation on February 16, 2012, at 12:45 p.m. of the medication room with Licensed Practical Nurse (LPN) #8 revealed the following: 1 box of 4 patches of Scopolamine 15mg (milligrams) with 3 patches left and taped to the cabinet door without a resident label on the box, and one 10 ml (milliliter) bottle Novolin R insulin opened and dated 12/22/11 in the refridgerator.<br><br>Interview with LPN #8, on February 16, 2012, at | {F 431} | in order and that an account of all controlled drugs is maintained and periodically reconciled.<br><br>Drugs and biological used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>**Corrective Action Plan:**<br><br>1. (a) The Scopolamine patches, Lantus insulin and Novolin R insulin was disposed of following facility policy on 2/16/12 by the Director of Nursing.<br><br>(b) Narcotic control sheets were reviewed and reconciled as needed on 2/16/12 to show current count by the Director of Nursing.<br><br>2. All residents receiving a controlled substance have the potential to be affected. No other residents had | |

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 431} | Continued From page 25<br>12:45 p.m., in the medication room, confirmed the insulin had expired. Interview on February 16, 2012, at 12:45 p.m., with the Director of Nursing, in the medication room, confirmed the Scopolamine patches were not to be taped to the cabinet door.<br><br>Observation on February 16, 2012, of medication cart #1 at 1:00 pm with LPN #8 revealed one 10 ml bottle of Lantus insulin with approximately 4 ml left available for resident use opened and dated 1/12/12. Interview with LPN #8 at this time confirmed the insulin had expired.<br><br>Observation on February 16, 2012, at 1:20 p.m. of medication cart #3 with LPN #7 revealed one 10ml bottle Lantus insulin dated as opened on 1/3/12 with approx 1/3 left. Interview at this time with LPN #7 confirmed the insulin had expired.<br><br>Review of facility policy, Medications, revealed "...Routine checks must be accomplished to ensure that expired medications are discarded..."<br><br>Review of the Controlled Drug Receipt/Record/Disposition Form dated December 3, 2011 through January 3, 2012, revealed, "...Morphine Sulfate-20mg/ml-conc (concentrate)...(0.25ml) po/sl (sublingual) every four hours as needed..." Further review revealed no reconciliation of the Morphine Sulfate from December 3, 2011, through January 3, 2012.<br><br>Review of the Controlled Drug Receipt/Record/Disposition form dated January 4, 2012, through January 30, 2012, revealed, "...Morphine Sulfate-20mg/ml-conc 0.5 ml po/sl every six hours..." Further review revealed no | {F 431} | narcotic sheets that were not reconciled.<br><br>3. Licensed nurses were in-serviced on 2/17/12, 2/29/12, and 3/15/12 by the Director of Nursing on the procedure for medication storage, expiration dates, and reconciliation of controlled drug sheets.<br><br>4. The Assistant Director of Nursing or designee will perform random audits of the medication carts, medication room, and controlled sheets for compliance for six (6) weeks. Findings will be reported in the morning QA meeting.<br><br>**Completion date: 3/22/12** | |

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 431} | Continued From page 26<br>reconciliation of the Morphine Sulfate from January 4, 2012 through January 30, 2012.<br><br>Review of the policy, Controlled Drug Accountability Procedure, revealed "...The count of each controlled substance must be audited every shift by the nurse coming on duty and the nurse going off duty. Both nurses must sign the Narcotic Control Record..."<br><br>Interview on February 17, 2012, at 12:20 p.m., by phone with the pharmacy consultant, confirmed the doses remaining must be entered to verify the correct narcotic count at the end of the shift. | {F 431} | | |
| {F 441} SS=F | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. | {F 441} | **F441**<br><br>**483.65 Infection Control, Prevent Spread, Linens**<br><br>**SS=F**<br><br>**Requirement:**<br><br>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. | |

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 441} | Continued From page 27<br>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.<br>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview the facility failed to maintain sanitary pill cutters/crushers on three of three medication carts, and the facility failed to ensure infection control measures were maintained in common areas to prevent the spread of infection and prevent potential contamination of a wound for one resident (#111) of one random observation.<br><br>The findings included:<br><br>Observation of medication cart #1, on February 8, 2012, at 9:47 a.m., on the 200 hallway, revealed two pill cutters and the Silent Night pill crusher with debris (pill peices from previous medication preparations) and not maintained in sanitary condition for medication administration. Interview with Licensed Practical Nurse (LPN) #7 at the time of the observation confirmed the pill cutters and pill crusher were unsanitary. | {F 441} | **Corrective Action Plan:**<br><br>1. (a) Pill cutters were replaced and the pill crushers were cleaned on each of the three (3) med carts on 2/8/12 by the Director of Nursing.<br><br>(b) Resident #111's foot bandage was appropriately covered on 2/15/12 by the Director of Nursing.<br><br>2. (a.) The facility has determined that all residents have the potential to be affected. (b) No other residents were noted with exposed uncovered dressings.<br><br>3. Licensed nurses were in-serviced on 2/17/12, 2/29/12, and 3/15/12 by the Director of Nursing on the protocol for Infection Control to include but not limited to: cleaning of equipment and appropriate covering of wounds to prevent the spread of infection.<br><br>4. The Assistant Director of Nursing or designee will conduct random rounds to ensure Infection Control Protocol compliance is maintained for six (6) weeks. Findings will be reported in the morning QA meeting.<br><br>**Completion date: 3/22/12** | |



109

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 441} | Continued From page 28<br><br>Observation of medication cart #2 on February 8, 2012, at 9:50 a.m, in front of the Nurse's Station, revealed the Silent Night pill crusher had blood splattered on the side and was not maintained in sanitary condition for medication administration. Interview with LPN #5, at the time of the observation, confirmed the pill crusher was unsanitary.<br><br>Observation of medication cart #3, on February 8, 2012, at 9:53 a.m., in front of the Nurse's Station, revealed the Silent Night pill crusher had ensure (liquid oral supplement) and other debris on it and was not maintained in sanitary condition for medication administration. Interview with LPN #6 at the time of the observation, confirmed the pill crusher was unsanitary.<br><br>Observation on February 15, 2012, at 4:25 p.m, revealed resident #111 sitting in a wheelchair near the nurse's station with other residents. Observation revealed the resident had a bandaged left foot resting on the tile floor with no protective footwear in place.<br><br>Interview with the Director of Nursing (DON), at the nurse's station, at the time of the observation, confirmed the resident's dressing/bandage should be covered by some type of protective footwear and not resting on the floor uncovered. | {F 441} | | |
| {F 490} SS=E | 483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING<br><br>A facility must be administered in a manner that enables it to use its resources effectively and | {F 490} | | |



110

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 490} | Continued From page 29<br>efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, facility policy review, review of training seminar information, review of Guidance for Industry and FDA (Federal Drug Administration) staff, dated 2006, observation, and interview, the facility failed to be administered in a manner to ensure seven residents (#41, #60, #18, #55, #94, #57, #83) were provided a safe enviornment of fourty-three residents reviewed. The facility's failure to provide a system to assess for the use of siderails, to reduce or eliminate full siderails to prevent falls and to reduce the risk of entrapment placed residents #41, #60, and #18 and any resident who used full side rails, in Immediate Jeopardy.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included:<br><br>Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The | {F 490} | **F490**<br><br>**483.75 Effective Administration/Resident Well-Being**<br><br>**SS=E**<br><br>**Requirement:**<br><br>A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.<br><br>**Corrective Action Plan:**<br><br>1. As of 3/5/12, the facility is providing a safe environment through the comprehensive assessment of each resident to meet the resident's needs and maintaining their optimal physical, mental and psychosocial well being.<br><br>(a) Upon review of the Fall Risk Assessment on 2/6/12 completed by the licensed nurse the systematic review of risk factors indicated a risk | |



111

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 490} | Continued From page 29<br>efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, facility policy review, review of training seminar information, review of Guidance for Industry and FDA (Federal Drug Administration) staff, dated 2006, observation, and interview, the facility failed to be administered in a manner to ensure seven residents (#41, #60, #18, #55, #94, #57, #83) were provided a safe enviornment of fourty-three residents reviewed. The facility's failure to provide a system to assess for the use of siderails, to reduce or eliminate full siderails to prevent falls and to reduce the risk of entrapment placed residents #41, #60, and #18 and any resident who used full side rails, in Immediate Jeopardy.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included:<br><br>Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The | {F 490} | score of 24 (high risk) for resident #41. Based on the risk factors from his Fall Risk Assessment it was determined that he was not a candidate for the use of side rails due to impaired judgment, incontinence, and history of falls from his bed. The side rails were removed on 2/6/12 by the Maintenance Director. The nursing administration staff communicated changes made to the resident's plan of care (removal of side rails and low bed with one mat) to the direct caregivers on the Nurse Aide Communication Worksheet and the Care plans on 2/6/12. On 2/17/12 a telephone order was obtained by the charge nurse and the Director of Nursing to discontinue the resident's bed and chair alarm and use a sensor pressure pad for his bed and chair. The resident remains on a low bed with one mat at bedside after receiving a telephone order from the physician on 2/23/12. The resident's care plan was updated on 2/24/12 by the Interim MDS Coordinator to reflect the current orders and interventions (other interventions: involve in activities, slip resistant footwear, may place in the sight of | |



112

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-039

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 490} | Continued From page 29<br>efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, facility policy review, review of training seminar information, review of Guidance for Industry and FDA (Federal Drug Administration) staff, dated 2006, observation, and interview, the facility failed to be administered in a manner to ensure seven residents (#41, #60, #18, #55, #94, #57, #83) were provided a safe enviornment of fourty-three residents reviewed. The facility's failure to provide a system to assess for the use of siderails, to reduce or eliminate full siderails to prevent falls and to reduce the risk of entrapment placed residents #41, #60, and #18 and any resident who used full side rails, in Immediate Jeopardy.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included:<br><br>Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The | {F 490} | staff when awake, rest periods as needed, family at bedside sessions throughout the day, get patient up when trying to get out of bed, offer snacks, attempt to keep resident dry or clean immediately after incontinent episode). The care plan was audited by the Nursing Administration Staff (Director of Nursing, Staffing Coordinator, and MDS Coordinator) to ensure that the plan of care had been updated to reflect the resident's current status on 2/24/12. Resident was hospitalized from 2/24/12 to 3/2/12, returning with a change in medical status. The Fall Risk Assessment updated on 3/5/12 by the Director of Nursing reflects that resident no longer attempts to self transfer, requiring assistance of 2 for transfers. The resident no longer requires constant supervision for the prevention of falls. He is on the FROG Program that provides closer observation from various staff members. Resident was transferred to the hospital again on 3/9/12 after visit by attending physician. MDS Coordinator completed a | |



113

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 490} | Continued From page 29<br>efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, facility policy review, review of training seminar information, review of Guidance for Industry and FDA (Federal Drug Administration) staff, dated 2006, observation, and interview, the facility failed to be administered in a manner to ensure seven residents (#41, #60, #18, #55, #94, #57, #83) were provided a safe enviornment of fourty-three residents reviewed. The facility's failure to provide a system to assess for the use of siderails, to reduce or eliminate full siderails to prevent falls and to reduce the risk of entrapment placed residents #41, #60, and #18 and any resident who used full side rails, in Immediate Jeopardy.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included:<br><br>Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The | {F 490} | discharge assessment on 3/9/12. Resident was readmitted on 3/15/12 with admitting Charge Nurse completing Fall Risk Assessment and Evaluation for the Use of Side Rails with the recommendation to be that side rails were not indicated at that time. Resident's care plan was updated on 3/21/12 with a significant change assessment. Resident's care plan is updated per MDS and/or Charge Nurse on ongoing bases and as needed with any new orders, interventions, or changes.<br><br>(b) Resident #18 The side rails that were in place during the survey were immediately changed to full anti-entrapment rails on 2/6/12 by the Maintenance Director after receiving a physician's order. The measurements for the bed zones were obtained by the Maintenance Director on 2/6/12 using a standard tape measure with measurements. The Staffing Coordinator wrote a narrative note in the nurses notes on 2/6/12 describing the resident with | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/201
FORM APPROVE
OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 490} | Continued From page 29<br>efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, facility policy review, review of training seminar information, review of Guidance for Industry and FDA (Federal Drug Administration) staff, dated 2006, observation, and interview, the facility failed to be administered in a manner to ensure seven residents (#41, #60, #18, #55, #94, #57, #83) were provided a safe enviornment of fourty-three residents reviewed. The facility's failure to provide a system to assess for the use of siderails, to reduce or eliminate full siderails to prevent falls and to reduce the risk of entrapment placed residents #41, #60, and #18 and any resident who used full side rails, in Immediate Jeopardy.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included:<br><br>Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The | {F 490} | limited functional status using the side rails as a restraint. A Physical Restraint Assessment was updated on 2/6/12 for the use of side rails. A Side Rail Assessment and Informed Consent was signed by the family on 2/13/12. On 2/20/12 the MDS Coordinator completed an Evaluation for use of Side Rails with a reduction in side rails from full (anti-entrapment) to ½ rails, the physician was notified and order was obtained for ½ rails. The measurements for the bed zones were obtained by the Maintenance Director on 2/20/12. On 2/23/12 the resident was evaluated again for side rail reduction by the Staffing Coordinator, the resident's side rails was eliminated and the resident was placed on a low bed with mats. The Physical Restraint Assessment was completed on 2/28/12 by the Staffing Coordinator for the elimination of side rails and the use of a low bed with mats after receiving a physician's order. The care plan was audited by the Nursing Administration Staff to ensure that the plan of care had been updated to reflect the resident's current status on | |



116

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/20
FORM APPROVE
OMB NO. 0938-03

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 490} | Continued From page 29<br>efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, facility policy review, review of training seminar information, review of Guidance for Industry and FDA (Federal Drug Administration) staff, dated 2006, observation, and interview, the facility failed to be administered in a manner to ensure seven residents (#41, #60, #18, #55, #94, #57, #83) were provided a safe enviornment of fourty-three residents reviewed. The facility's failure to provide a system to assess for the use of siderails, to reduce or eliminate full siderails to prevent falls and to reduce the risk of entrapment placed residents #41, #60, and #18 and any resident who used full side rails, in Immediate Jeopardy.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included:<br><br>Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The | {F 490} | 2/29/12. . On 3/5/12 resident rolled out of bed with a small laceration to upper lip with intervention to check placement of furniture and remove if in pathway. Keep room free of clutter for safety, Bowel and bladder program to determine habit time, and Falls Reduced Our Goal, FROG Program. Care plan was updated to reflect new interventions for 3/5. 3/13 resident was found in room 129 bathroom with one shoe on. Resident had gotten up from her wheel chair in another resident's room, with interventions for proper footwear (nonskid) replace footwear when resident removes as allows with physical therapy to screen. On 3/15, further intervention was added to get up after breakfast as desires after further investigation of fall on 3/13. Fall on 3/17 where resident rolled from the bed in her sleep, bed was in lowest position with mats on both sides, no injury | |



117

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 490} | Continued From page 29<br>efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, facility policy review, review of training seminar information, review of Guidance for Industry and FDA (Federal Drug Administration) staff, dated 2008, observation, and interview, the facility failed to be administered in a manner to ensure seven residents (#41, #60, #18, #55, #94, #57, #83) were provided a safe enviornment of fourty-three residents reviewed. The facility's failure to provide a system to assess for the use of siderails, to reduce or eliminate full siderails to prevent falls and to reduce the risk of entrapment placed residents #41, #60, and #18 and any resident who used full side rails, in Immediate Jeopardy.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included:<br><br>Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The | {F 490} | noted, intervention to add pool noodles to define perimeter of the bed with all above interventions added to the care plan as implemented. Resident's care plan is updated per MDS and/or Charge Nurse on an ongoing bases and as needed with any new orders, interventions, or changes.<br><br>(c) Resident # 60 The side rails that were in place during the survey were immediately changed to full anti-entrapment rails (prior to the exit of the surveyors) on 2/6/12 by the Maintenance Director. The measurements for the bed zones were obtained by the Maintenance Director on 2/6/12 using a standard tape measure. The Side Rail Assessment and Informed Consent Form (one form) was later completed by the Staffing Coordinator on 2/6/12 for the use of side rails with a reduction from full side rails to ½ side rails after receiving a physician's order for the use of ½ rails by the Staffing Coordinator (after the exit of the surveyors for the evening) that were changed out per | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/20
FORM APPROVE
OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 490} | Continued From page 29<br>efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, facility policy review, review of training seminar information, review of Guidance for Industry and FDA (Federal Drug Administration) staff, dated 2006, observation, and interview, the facility failed to be administered in a manner to ensure seven residents (#41, #60, #18, #55, #94, #57, #83) were provided a safe enviornment of fourty-three residents reviewed. The facility's failure to provide a system to assess for the use of siderails, to reduce or eliminate full siderails to prevent falls and to reduce the risk of entrapment placed residents #41, #60, and #18 and any resident who used full side rails, in Immediate Jeopardy.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included:<br><br>Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The | {F 490} | the Maintenance Director. The bed zone measurements were obtained by the Maintenance Director on 2/6/12. A Pre-Restraint Assessment was completed on 2/21/12 by the Staffing Coordinator that indicated side rails being used as a restraint and assisting the resident. Resident was transferred to hospital on 2/26/12. The Interim MDS Coordinator completed a Discharge Assessment on 2/29/12 which reflected the use of side rails as a restraint (as ½ rails were used until 2/23/12 during the 7 day look back period). The resident was reassessed upon return to the facility on 3/12/12 by the admitting Charge Nurse who completed an Evaluation for the use of Side Rails and a Fall Risk Assessment with the recommendation for no side rails indicated at this time. The MDS Coordinator completed a 5 day Readmission Assessment on 3/22/12. (A 14 day Assessment was completed on 3/29/12). | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/20
FORM APPROVI
OMB NO. 0938-03

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 490} | Continued From page 29<br>efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, facility policy review, review of training seminar information, review of Guidance for Industry and FDA (Federal Drug Administration) staff, dated 2006, observation, and interview, the facility failed to be administered in a manner to ensure seven residents (#41, #60, #18, #55, #94, #57, #83) were provided a safe enviornment of fourty-three residents reviewed. The facility's failure to provide a system to assess for the use of siderails, to reduce or eliminate full siderails to prevent falls and to reduce the risk of entrapment placed residents #41, #60, and #18 and any resident who used full side rails, in Immediate Jeopardy.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included:<br><br>Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The | {F 490} | Resident's care plan is updated per MDS and/or Charge Nurse on an ongoing base and as needed with any new orders, interventions, or changes.<br><br>(d) Resident # 57 A telephone order was received from the resident's physician for the use of ½ side rails on *2/10/12*. The resident was assessed on 2/20/12 using the Evaluation for use of Side Rails (for the evaluation of side rail use) indicating the use of ½ side rails by the Staffing Coordinator. A Pre-Restraint Assessment was completed on 2/21/12 by the Director of Nursing that indicated side rails are used as a restraint. On 2/24/12 another Evaluation for the use of Side Rail was completed by the Staffing Coordinator indicating the elimination of ½ side rails (no side rails are in place at this time). As of 2/24/12 the resident's current interventions include: the locking of wheel chair prior to transfer, offer rest periods, assist to the bathroom during rounds and as needed, bed in lowest position, a chair sensor pad. | |



120

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/201
FORM APPROVE
OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 490} | Continued From page 29<br>efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, facility policy review, review of training seminar information, review of Guidance for Industry and FDA (Federal Drug Administration) staff, dated 2006, observation, and interview, the facility failed to be administered in a manner to ensure seven residents (#41, #60, #18, #55, #94, #57, #83) were provided a safe enviornment of fourty-three residents reviewed. The facility's failure to provide a system to assess for the use of siderails, to reduce or eliminate full siderails to prevent falls and to reduce the risk of entrapment placed residents #41, #60, and #18 and any resident who used full side rails, in Immediate Jeopardy.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included:<br><br>Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The | {F 490} | The care plan was audited by the Nursing Administration Staff to ensure that the plan of care had been updated to reflect the resident's current status on 2/29/12. The care plan was audited by the Nursing Administration Staff to ensure that the plan of care had been updated to reflect the resident's current status on 2/29/12. The resident's care plan was reviewed by the Director of Nursing on 3/7/12 and evaluated for fall prevention strategies and deemed the intervention for constant supervision during toileting was inappropriate. After review of current interventions on 3/7/12 by the Director of Nursing and further investigation of the incident (with intervention not to leave unattended) it was determined that the intervention was implemented before a full root cause analysis was conducted (the intervention was removed as of 2/24/12 interventions above). As of 3/22/12, current interventions, the resident remains on the FROG (Falls Reduced Our Goal) program, participates in restorative with ambulation "walk to dine program", low bed with mats, | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/20
FORM APPROVI
OMB NO. 0938-03

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 490} | Continued From page 29<br>efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, facility policy review, review of training seminar information, review of Guidance for Industry and FDA (Federal Drug Administration) staff, dated 2006, observation, and interview, the facility failed to be administered in a manner to ensure seven residents (#41, #60, #18, #55, #94, #57, #83) were provided a safe enviornment of fourty-three residents reviewed. The facility's failure to provide a system to assess for the use of siderails, to reduce or eliminate full siderails to prevent falls and to reduce the risk of entrapment placed residents #41, #60, and #18 and any resident who used full side rails, in Immediate Jeopardy.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included:<br><br>Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The | {F 490} | antiroll back brakes, the locking of wheel chair prior to transfer, offer rest periods, ask resident frequently on rounds if she would like anything or needs assist to the bathroom during rounds and as needed, further monitoring and interventions will continue to prevent falls. Resident's care plan is current and updated per MDS and/or Charge Nurse on an ongoing bases and as needed with any new orders, interventions, or changes.<br><br>(e) Resident #94 The facility staff provides supervision through routine rounds (minimum of every 2 hours), during care delivery, activities, and meals. The chair sensor pad was discontinued on 3/5/12 by the Director of Nursing after reviewing current interventions. After placing the resident in the correct wheel chair with anti-lock brakes on 2/6/12 the resident was identified not to be at risk for falls of a similar incident (wheel chair rolling back). The resident utilizes the wheel chair to push himself into a standing position; the anti-lock brakes prevent the chair | |



122

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 490} | Continued From page 29<br>efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, facility policy review, review of training seminar information, review of Guidance for Industry and FDA (Federal Drug Administration) staff, dated 2006, observation, and interview, the facility failed to be administered in a manner to ensure seven residents (#41, #60, #18, #55, #94, #57, #83) were provided a safe enviornment of fourty-three residents reviewed. The facility's failure to provide a system to assess for the use of siderails, to reduce or eliminate full siderails to prevent falls and to reduce the risk of entrapment placed residents #41, #60, and #18 and any resident who used full side rails, in Immediate Jeopardy.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included:<br><br>Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The | {F 490} | from rolling providing the resident with stability. An identifier with the resident's name was attached to the wheel chair on 2/29/12. The resident's care plan was reviewed and updated by the Director of Nursing on 2/29/12 to reflect the resident's current status. After review of current interventions on 3/7/12 by the Director of Nursing and further investigation of the incident (with intervention not to leave unattended was not identified as an appropriate intervention to prevent falls). The resident remains on the FROG program and does not require constant supervision, further monitoring and interventions will continue to prevent falls. Resident had fall on 3/21/12 from the bed while attempting to get urinal that had fallen in the floor. After Event Note review and occurrence investigation completed with the intervention to place urinal within reach and apply nonskid socks. In addition, intervention was added 3/30 to | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 490} | Continued From page 29<br>efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, facility policy review, review of training seminar information, review of Guidance for Industry and FDA (Federal Drug Administration) staff, dated 2006, observation, and interview, the facility failed to be administered in a manner to ensure seven residents (#41, #60, #18, #55, #94, #57, #83) were provided a safe enviornment of fourty-three residents reviewed. The facility's failure to provide a system to assess for the use of siderails, to reduce or eliminate full siderails to prevent falls and to reduce the risk of entrapment placed residents #41, #60, and #18 and any resident who used full side rails, in Immediate Jeopardy.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included:<br><br>Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The | {F 490} | attach personal item bag to head of bed to place urinal in for resident's access. No other changes have been indicated. Resident's care plan is current and updated per MDS and/or Charge Nurse on an ongoing bases and as needed with any new orders, interventions, or changes.<br><br>(f) Resident #55 care plan was reviewed and modified on 2/14/12 by the MDS Coordinator and reflected the resident's current status. No further assessments could be completed due to the resident expiring on 2/16/12.<br><br>(g) **Resident #83** *The recapitalization orders were signed by the physician for 2/2/12 included an order for the use of side rails.* An assessment was completed on 2/6/12 using a Pre-Restraint Assessment for the use of ¾ side rails completed by the MDS Coordinator indicating a restraint was recommended related to cognitive impairment, | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/20
FORM APPROVE
OMB NO. 0938-03

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 490} | Continued From page 29<br>efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, facility policy review, review of training seminar information, review of Guidance for Industry and FDA (Federal Drug Administration) staff, dated 2006, observation, and interview, the facility failed to be administered in a manner to ensure seven residents (#41, #60, #18, #55, #94, #57, #83) were provided a safe enviornment of fourty-three residents reviewed. The facility's failure to provide a system to assess for the use of siderails, to reduce or eliminate full siderails to prevent falls and to reduce the risk of entrapment placed residents #41, #60, and #18 and any resident who used full side rails, in Immediate Jeopardy.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included:<br><br>Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The | {F 490} | requiring physical assistance, and unaware of safety issues. On 2/20/12 an Evaluation for the use of Side Rail Assessment was completed by the MDS Coordinator indicating the resident was unaware of safety needs, cognitive impairment, and requiring physical assistance utilizing ¾ side rails. A new Evaluation for the use of Side Rails was completed on 2/23/12 by the Director of Nursing for the reduction of side rails from ¾ to ½. The resident's Physical Restraint Assessment was updated on 2/23/12 by the Director of Nursing for the restraint reduction *and* new orders received for the use of ½ side rails. On 2/28/12, an Evaluation for the use of Side Rails and Physical Restraint Assessment was completed by the Director of Nursing indicating the elimination of ½ rails and placed on low bed with mats. The care plan was audited by the Nursing | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/20
FORM APPROVE
OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 490} | Continued From page 29<br>efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, facility policy review, review of training seminar information, review of Guidance for Industry and FDA (Federal Drug Administration) staff, dated 2006, observation, and interview, the facility failed to be administered in a manner to ensure seven residents (#41, #60, #18, #55, #94, #57, #83) were provided a safe enviornment of fourty-three residents reviewed. The facility's failure to provide a system to assess for the use of siderails, to reduce or eliminate full siderails to prevent falls and to reduce the risk of entrapment placed residents #41, #60, and #18 and any resident who used full side rails, in Immediate Jeopardy.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included:<br><br>Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The | {F 490} | Administration Staff to ensure that the plan of care had been updated to reflect the resident's current status on 2/29/12. Care plan is current to resident's status and is updated per MDS and/or Charge Nurse on an ongoing bases and as needed with any new orders, interventions, or changes.<br>2. (a) The Nursing Administration Staff(Director of Nursing, MDS Coordinator, and Staffing Coordinator) reviewed all residents using side rails, and the resident's individual fall risk assessment scores to identify those that may be at risk for injury, and assessing and coding the resident's assessment correctly. Residents using side rails as a restraint were identified and care planned accordingly. A comprehensive assessment was completed; interventions were modified as needed and placed on the individuals care plan. The Administration Team (Administrator, Director of Nursing, and Assistant Director of Nursing, Maintenance Supervisor, Social Services/Admissions | |



126

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 490} | Continued From page 29<br>efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, facility policy review, review of training seminar information, review of Guidance for Industry and FDA (Federal Drug Administration) staff, dated 2006, observation, and interview, the facility failed to be administered in a manner to ensure seven residents (#41, #60, #18, #55, #94, #57, #83) were provided a safe enviornment of fourty-three residents reviewed. The facility's failure to provide a system to assess for the use of siderails, to reduce or eliminate full siderails to prevent falls and to reduce the risk of entrapment placed residents #41, #60, and #18 and any resident who used full side rails, in Immediate Jeopardy.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included:<br><br>Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The | {F 490} | Director, MDS Coordinator, Food Service Supervisor, Activity Director, and/or Medical Director) developed a Side Rail Policy with the involvement of the Medical Director with implementation on 2/28/12 to include the utilization of the Evaluation for the use of Side Rail Assessment.<br><br>(b) A total of 65 residents were identified on 2/6/12 as having side rails attached to their bed frame (ranging from ¼ to full side rails). The nursing administration Team (Director of Nursing, Staffing, Coordinator and MDS Coordinator) assessed residents using side rails utilizing the Evaluation for the use of Side Rails on 2/28/12 and 2/29/12. These tools (Side Rail Assessment and Informed Consent Form, Evaluation for the use of Side Rails, Pre-Restraint Assessment, and the Physical Restraint Assessment) were used for the purpose of assessing residents using side rails to | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/20
FORM APPROVED
OMB NO. 0938-03

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 490} | Continued From page 29<br>efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, facility policy review, review of training seminar information, review of Guidance for Industry and FDA (Federal Drug Administration) staff, dated 2006, observation, and interview, the facility failed to be administered in a manner to ensure seven residents (#41, #60, #18, #55, #94, #57, #83) were provided a safe enviornment of fourty-three residents reviewed. The facility's failure to provide a system to assess for the use of siderails, to reduce or eliminate full siderails to prevent falls and to reduce the risk of entrapment placed residents #41, #60, and #18 and any resident who used full side rails, in Immediate Jeopardy.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included:<br><br>Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The | {F 490} | determine if side rails were needed and/or could be reduced; notification of family and/or resident of the use of side rails/restraints, to determine if a restraint was recommended, and to review the resident for possible reduction of a restraint. The Pre-Restraint Assessment was completed for residents using side rails as restraints to assess residents using side rails to determine if side rails were recommended as a restraint on 2/28/12 by the Nursing Administration Team, with findings documented on the resident's individual assessment form (Side Rail Assessment and Informed Consent Form, Evaluation for the use of Side Rails, Pre-Restraint Assessment and/or the Physical Restraint Assessment). Through the individual resident assessment and monitoring of side rail use, the facility has been able to reduce the use of side rails with a | |



128

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/20
FORM APPROVE
OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 490} | Continued From page 29<br>efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, facility policy review, review of training seminar information, review of Guidance for Industry and FDA (Federal Drug Administration) staff, dated 2006, observation, and interview, the facility failed to be administered in a manner to ensure seven residents (#41, #60, #18, #55, #94, #57, #83) were provided a safe enviornment of fourty-three residents reviewed. The facility's failure to provide a system to assess for the use of siderails, to reduce or eliminate full siderails to prevent falls and to reduce the risk of entrapment placed residents #41, #60, and #18 and any resident who used full side rails, in Immediate Jeopardy.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included:<br><br>Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The | {F 490} | current total of 4 residents (no full rails). Side rails that were reduced or removed by the Maintenance Director based on the resident's individual assessment results by nurse administration beginning on 2/6/12 through 2/29/12. The Maintenance Director and the Maintenance Assistant obtained measurements of all remaining side rails using a standard tape measure. Measurements were obtained with the bed in a flat and articulated position. All findings met the FDA recommendations as referenced in the FDA Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment. Any side rail that measured outside the FDA recommendations were replaced as needed with anti-entrapment rails, shorter side rails (1/4, ½, and 3/4) or eliminated as needed based on the resident's individual assessments and/or for non-use. | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/20
FORM APPROVE
OMB NO. 0938-03

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 490} | Continued From page 29<br>efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, facility policy review, review of training seminar information, review of Guidance for Industry and FDA (Federal Drug Administration) staff, dated 2006, observation, and interview, the facility failed to be administered in a manner to ensure seven residents (#41, #60, #18, #55, #94, #57, #83) were provided a safe enviornment of fourty-three residents reviewed. The facility's failure to provide a system to assess for the use of siderails, to reduce or eliminate full siderails to prevent falls and to reduce the risk of entrapment placed residents #41, #60, and #18 and any resident who used full side rails, in Immediate Jeopardy.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included:<br><br>Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The | {F 490} | (c) *The resident's physician,* family member and/or residents were made aware of side rail assessments/restraint findings on 2/6/12, *obtaining new orders as needed* by the Nursing Administration Team, *the family and/or resident provided* verbal consent for the use of side rail/restraint as indicated. Ongoing communication will be discussed with families/residents regarding the use of side rails and restraint upon admission and/or as assessment findings change, by the Admission Coordinator, Charge Nurse or Nurse Administration Team.<br>3.(a) The Administrator and Director of Nursing received in-service training on 2/7/12 & 2/21/12, by the Regional Nurse Consultant. The in-service covered areas but not limited to: side rail standards, assessment prior to and ongoing use of restraints/side rails, resident assessments, revision of care | |



130

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/20
FORM APPROV
OMB NO. 0938-03

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETIOI DATE |
|---|---|---|---|---|
| {F 490} | Continued From page 29<br>efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, facility policy review, review of training seminar information, review of Guidance for Industry and FDA (Federal Drug Administration) staff, dated 2006, observation, and interview, the facility failed to be administered in a manner to ensure seven residents (#41, #60, #18, #55, #94, #57, #83) were provided a safe enviornment of fourty-three residents reviewed. The facility's failure to provide a system to assess for the use of siderails, to reduce or eliminate full siderails to prevent falls and to reduce the risk of entrapment placed residents #41, #60, and #18 and any resident who used full side rails, in Immediate Jeopardy.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included:<br><br>Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The | {F 490} | plans, investigation of occurrences (falls), implementation of interventions to reduce the occurrence of incidents, monitoring effectiveness of interventions, referring residents for assessment by therapist for appropriate interventions, job responsibilities, abuse protocol (list not all inclusive: investigation, reporting, screening of employees, employee training). The facility participates in the restraint reduction collaborative with Q-Source. The Administrator contacted the Q-Source representative who registered the Director of Nursing, Assistant Director of Nursing, Activity Director and MDS Coordinator for a ***Physical Restraint & Pressure Ulcer Regional Collaborative Learning Session*** on April10, 2012.<br><br>(b) The Regional Director of Operations in-serviced the Administrator, the Maintenance | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/14/20
FORM APPROVED
OMB NO. 0938-03

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 45457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 490} | Continued From page 29<br>efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, facility policy review, review of training seminar information, review of Guidance for Industry and FDA (Federal Drug Administration) staff, dated 2006, observation, and interview, the facility failed to be administered in a manner to ensure seven residents (#41, #60, #18, #55, #94, #57, #83) were provided a safe enviornment of fourty-three residents reviewed. The facility's failure to provide a system to assess for the use of siderails, to reduce or eliminate full siderails to prevent falls and to reduce the risk of entrapment placed residents #41, #60, and #18 and any resident who used full side rails, in Immediate Jeopardy.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included:<br><br>Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The | {F 490} | Director and the Maintenance Assistant regarding the FDA Safety Alert: Entrapment Hazards with Hospital Bed Side Rails and shared by the surveyors during facility demonstration of measuring bed zones (included flat and articulated positions) on 2/7/12. The Maintenance Director and the Maintenance Assistant were able to demonstrate competency through a return demonstration on 2/7/12 on measuring the bed zones in flat and articulated positions (related to the information provided during the survey). The Regional Director of Operations also in-serviced the Maintenance Director and Assistant on 2/13/12 regarding The FDA Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment dated March 10, 2006.<br><br>(c) The Administration Team (Administrator, Director of Nursing, and Assistant Director of | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/
FORM APPRO
OMB NO. 0938-0

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETIC DATE |
|---|---|---|---|---|
| {F 490} | Continued From page 29<br>efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, facility policy review, review of training seminar information, review of Guidance for Industry and FDA (Federal Drug Administration) staff, dated 2006, observation, and interview, the facility failed to be administered in a manner to ensure seven residents (#41, #60, #18, #55, #94, #57, #83) were provided a safe enviornment of fourty-three residents reviewed. The facility's failure to provide a system to assess for the use of siderails, to reduce or elliminate full siderails to prevent falls and to reduce the risk of entrapment placed residents #41, #60, and #18 and any resident who used full side rails, in Immediate Jeopardy.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included:<br><br>Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The | {F 490} | Nursing, MDS Coordinator, Maintenance Supervisor, Social Services Director, Activity Director, Food Service Supervisor, Bookkeeper, Therapy Team Leader/Therapy Program Manager, and/or Medical Director) developed a Side Rail Assessment Policy with the involvement of the Medical Director on 2/28/12 to include the utilization of the Evaluation for the use of Side Rail Assessment. The policy will assist the facility in reducing the use of side rails, prevent potential occurrences and reduce/eliminate entrapment risk associated to the use of side rails. The Side Rail Assessment Policy (attachment F) was reviewed with the staff during the in-service on 2/29/12 by the Director of Nursing.<br><br>(d) The Administrator and Director of Nursing will review patient information with the interdisciplinary team in the morning QA meeting, disbursing | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/20
FORM APPROV
OMB NO. 0938-03

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 490} | Continued From page 29<br>efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, facility policy review, review of training seminar information, review of Guidance for Industry and FDA (Federal Drug Administration) staff, dated 2006, observation, and interview, the facility failed to be administered in a manner to ensure seven residents (#41, #60, #18, #55, #94, #57, #83) were provided a safe enviornment of fourty-three residents reviewed. The facility's failure to provide a system to assess for the use of siderails, to reduce or eliminate full siderails to prevent falls and to reduce the risk of entrapment placed residents #41, #60, and #18 and any resident who used full side rails, in Immediate Jeopardy.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included:<br><br>Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The | {F 490} | information to appropriate caregivers, residents, and/or family members to obtain the residents highest physical functioning and psychosocial needs. The Administration team will consult with the Medical Director as needed for guidance in delivering patient care and the revision of policy and procedures.<br><br>4. (a) The Administrator or Director of Nursing will conduct random audits weekly through facility walking rounds, review of the 24 hour report, care plans, Nurse Aide Communication Sheets, Evaluation for the Use of Side Rails, and Nurse Event notes to ensure the appropriate procedures and policies are being followed. The Administrator will report findings in the morning Quality Assurance Meeting (Monday-Friday) and review with the Medical Director in the quarterly QA meeting and as needed.<br>(b) The Regional Nurse Consultant will conduct random audits of facility documentation | |



114

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 490} | Continued From page 30<br>facility developed a Side Rail Assessment Policy with the involvement of the Medical Director to include the utilization of the evaluation for the use of side rails. The facility provided evidence of side rail assessments for all residents, and removal of side rails when indicated, and evidence bed zone measurements were obtained to reduce or eliminate entrapment risk. The facility provided evidence Fall Risk Assessments, Pre-Restraint Assessments, and Physical Restraint Assessments were completed. The facility provided evidence of in-service for all staff and random audits to ensure compliance.<br><br>The facility will remain out of compliance at a "E" level until it provides an acceptable plan of correction to include continued monitoring to ensure the deficient practice does not recur and the facility's corrective measure could be reviewed and evaluated by the Quality Assurance Committee. | {F 490} | and random patient/staff interviews to ensure facility is maintaining compliance with facility, State and Federal Policies/Regulations.<br><br>(c) The Regional Director of Operations will conduct random audits during visits to ensure the facility is being operated following Facility, State, and Federal Policies/Regulations and maintaining the resident's optimal physical, mental and psychosocial well being. | |
| {F 501} SS=E | 483.75(i) RESPONSIBILITIES OF MEDICAL DIRECTOR<br><br>The facility must designate a physician to serve as medical director.<br><br>The medical director is responsible for implementation of resident care policies; and the coordination of medical care in the facility.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, facility policy review, observation and interview the Medical Director failed to provide oversight and participate in the development of policies and procedures to | {F 501} | **Completion Date: 3/22/12** | |



134

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/...
FORM APPROVED
OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 490} | Continued From page 30<br>facility developed a Side Rail Assessment Policy with the involvement of the Medical Director to include the utilization of the evaluation for the use of side rails. The facility provided evidence of side rail assessments for all residents, and removal of side rails when indicated, and evidence bed zone measurements were obtained to reduce or eliminate entrapment risk. The facility provided evidence Fall Risk Assessments, Pre-Restraint Assessments, and Physical Restraint Assessments were completed. The facility provided evidence of in-service for all staff and random audits to ensure compliance.<br><br>The facility will remain out of compliance at a "E" level until it provides an acceptable plan of correction to include continued monitoring to ensure the deficient practice does not recur and the facility's corrective measure could be reviewed and evaluated by the Quality Assurance Committee. | {F 490} | | |
| {F 501} SS=E | 483.75(i) RESPONSIBILITIES OF MEDICAL DIRECTOR<br><br>The facility must designate a physician to serve as medical director.<br><br>The medical director is responsible for implementation of resident care policies; and the coordination of medical care in the facility.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, facility policy review, observation and interview the Medical Director failed to provide oversight and participate in the development of policies and procedures to | {F 501} | **F 501**<br><br>**483.75(i) Responsible of Medical Director**<br><br>**SS=E**<br><br>**Requirement:**<br><br>The facility must designate a physician to serve as medical director. The medical director is responsible for implementation of resident care policies; and the | |



135

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 501} | Continued From page 31<br>ensure resident safety and ensure that residents with restraints were properly assessed, managed, and restraint reduction or elimination was implemented where appropriate.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included:<br><br>Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The facility developed a Side Rail Assessment Policy with the involvement of the Medical Director to include the utilization of the evaluation for the use of side rails. The facility provided evidence of side rail assessments for all residents, and removal of side rails when indicated, and evidence bed zone measurements were obtained to reduce or eliminate entrapment risk. The facility provided evidence Fall Risk Assessments, Pre-Restraint Assessments and Physical Restraint Assessments were completed. The facility provided evidence of in-service for all staff and random audits to ensure compliance.<br><br>~~The facility will remain out of compliance at a "E" level until it provides an acceptable plan of correction to include continued monitoring to ensure the deficient practice does not recur and~~ | {F 501} | coordination of medical care in the facility.<br><br>**Corrective Action Plan:**<br><br>1. The facility's Medical Director was made aware by the Administrator on 2/8/12 that the facility had received immediate jeopardy level deficiencies including F 490 for the manner in which the facility has been administrated. The Quality Assurance Committee met with the Medical Director on 2/23/12 to review deficiencies sited during the facility's recent annual survey. The Administrator reviewed the literature on The Food and Drug Administration Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment dated March 10, 2006. During the meeting with the Medical Director, the Administrator also reviewed the role of the Medical Director and the Quality Assurance process, | |



136

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETIO DATE |
|---|---|---|---|---|
| {F 501} | Continued From page 31<br>ensure resident safety and ensure that residents with restraints were properly assessed, managed, and restraint reduction or elimination was implemented where appropriate.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included:<br><br>Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The facility developed a Side Rail Assessment Policy with the involvement of the Medical Director to include the utilization of the evaluation for the use of side rails. The facility provided evidence of side rail assessments for all residents, and removal of side rails when indicated, and evidence bed zone measurements were obtained to reduce or eliminate entrapment risk. The facility provided evidence Fall Risk Assessments, Pre-Restraint Assessments and Physical Restraint Assessments were completed. The facility provided evidence of in-service for all staff and random audits to ensure compliance.<br><br>The facility will remain out of compliance at a "E" level until it provides an acceptable plan of correction to include continued monitoring to ensure the deficient practice does not recur and | {F 501} | assisting the facility with identifying problems, evaluating, and addressing concerns to improve resident outcome through the development and revision of policy and procedures as needed.<br><br>2. The Nursing Administration Staff (Director of Nursing, Staffing Coordinator, and MDS Coordinator) reviewed all residents using side rails, assessing and coding the resident's assessment correctly. Residents using side rails as a restraint were identified and care planned accordingly. A comprehensive assessment was completed; interventions were modified as needed and placed on the individuals care plan. The Administration Team (Administrator, Director of Nursing, and Assistant Director of Nursing, MDS Coordinator, Maintenance Supervisor, Social Services Director, Activity Director, Food Service Supervisor, Bookkeeper, Therapy Team Leader/Therapy Program | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETIO DATE |
|---|---|---|---|---|
| {F 501} | Continued From page 31<br>ensure resident safety and ensure that residents with restraints were properly assessed, managed, and restraint reduction or elimination was implemented where appropriate.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included:<br><br>Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The facility developed a Side Rail Assessment Policy with the involvement of the Medical Director to include the utilization of the evaluation for the use of side rails. The facility provided evidence of side rail assessments for all residents, and removal of side rails when indicated, and evidence bed zone measurements were obtained to reduce or eliminate entrapment risk. The facility provided evidence Fall Risk Assessments, Pre-Restraint Assessments and Physical Restraint Assessments were completed. The facility provided evidence of in-service for all staff and random audits to ensure compliance.<br><br>The facility will remain out of compliance at a "E" level until it provides an acceptable plan of correction to include continued monitoring to ensure the deficient practice does not recur and | {F 501} | Manager, and/or Medical Director) developed a Side Rail Policy with the involvement of the Medical Director with implementation on 2/28/12 to include the utilization of the Evaluation for the use of Side Rail Assessment.<br><br>3. The Administrator reviewed the functions and responsibilities with Medical Director on 2/23/12. The Administrator and/or Director of Nursing will notify the Medical Director as needed regarding issues that requires the revision and/or development of policies and procedures to meet the needs of resident and/or staff.<br><br>4. (a) The Administrator will review the functions of the Medical Director through random audits and ensure that the development/revision of policies or systems is completed in the quarterly QA meeting and as needed.<br><br>(b) The Administrator and Director of Nursing will review | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 501} | Continued From page 31<br>ensure resident safety and ensure that residents with restraints were properly assessed, managed, and restraint reduction or elimination was implemented where appropriate.<br><br>The facility provided a Credible Allegation of Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included:<br><br>Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The facility developed a Side Rail Assessment Policy with the involvement of the Medical Director to include the utilization of the evaluation for the use of side rails. The facility provided evidence of side rail assessments for all residents, and removal of side rails when indicated, and evidence bed zone measurements were obtained to reduce or eliminate entrapment risk. The facility provided evidence Fall Risk Assessments, Pre-Restraint Assessments and Physical Restraint Assessments were completed. The facility provided evidence of in-service for all staff and random audits to ensure compliance.<br><br>~~The facility will remain out of compliance at a "E"~~ level until it provides an acceptable plan of correction to include continued monitoring to ensure the deficient practice does not recur and | {F 501} | patient information with the interdisciplinary team in the morning QA meeting, disbursing information to appropriate caregivers, residents, and/or family members to obtain the residents highest physical functioning and psychosocial needs. The Administrator and/or Director of Nursing will notify the Medical Director as needed regarding issues that requires the revision and/or development of policies and procedures to meet the needs of resident and/or staff.<br><br>**Completion Date: 3/22/12** | |

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 501} | Continued From page 32<br>the facility's corrective measure could be reviewed and evaluated by the Quality Assurance Committee. | {F 501} | | |
| {F 502} SS=D | 483.75(j)(1) ADMINISTRATION<br><br>The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review and interview, the facility failed to obtain laboratory tests timely for three residents (#7, #41, and #60) of forty three residents reviewed.<br><br>The findings included:<br><br>Resident #7 was admitted to the facility on January 5, 2012, with diagnoses including Dementia with Depression, Atrial Fibrillation, and Anxiety.<br><br>Medical record review of the Interdisciplinary Plan of Care dated January 17, 2012, revealed "...risk for falls...risk for bleeding R/T (related to) anticoagulant use...labs as ordered..."<br><br>Medical record review of the Physician Admission Orders dated January 5, 2012, revealed "...repeat PT/INR (Prothrombin Time/International Ratio-lab test that measures blood clotting) next PT/INR due 2-5-12..."<br><br>Medical record of a Physician's Telephone order dated January 12, 2012, revealed "...Repeat | {F 502} | **F 502**<br><br>**483.75 (j)(1) Administration**<br><br>**SS=D**<br><br>**Requirement:**<br><br>The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.<br><br>**Corrective Action Plan:**<br><br>1. (a) Resident #7 had a PT/INR completed on 2/14/12 by the charge nurse with findings reported to the physician.<br><br>(b) As of 2/21/12 resident #41 has had PT/INR labs completed as ordered.<br><br>(c) As of 2/21/12 resident #60 has had PT/INR labs completed as ordered. | |



140

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 502} | Continued From page 33<br>PT/INR 2-3-12 DC (discontinue) order for PT/INR 2-5-12..."<br><br>Medical record review of the chart revealed no PT/INR results for February 3, 3012.<br><br>Medical record review of a Physician's Telephone order dated February 12, 2012, revealed "...Draw PT/INR on 2/14..."<br><br>Medical record review of Laboratory results dated February 14, 2012, revealed "...PT 17.0...INR 1.7..."<br><br>Interview with Director of Nursing (DON) on February 13, 2012, at 4:00 p.m., confirmed the residents PT/INR was due February 3, 2012, and the facility failed to obtain the laboratory test.<br><br>Resident #41 was admitted to the facility on September 23, 2011, and readmitted to the facility on October 24, 2012, with diagnoses including Alzheimer's Disease, Deep Vein Thrombosis and Hypertension.<br><br>Medical record review of a Physician's Telephone Order dated January 2, 2012, revealed "...Continue Coumadin (anticoagulant) 10 mg qd (every day) at 1600 (4:00 p.m.) repeat PT/INR (measures blood clotting)...in 2 weeks (January 16, 2012)..."<br><br>Review of the medical record revealed no laboratory results for PT/INR on January 16, 2012.<br><br>Medical record review of the Coumadin Flowsheet dated January 2012, revealed | {F 502} | 2. The DON audited the labs for all patients receiving Coumadin on 3/16/12 with no findings of missing PT/INR results.<br><br>3. Licensed nurses were in-serviced on 2/17/12, 2/29/12, and 3/15/12 on the process for obtaining labs as ordered.<br><br>4. The Director of Nursing or designee will conduct random chart audits weekly to ensure that PT/INR labs are completed as ordered for six (6) weeks. Findings will be reported in the morning QA meeting.<br><br>**Completion date: 3/22/12** | |



141

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 502} | Continued From page 34<br>"...1-19-2012...Lab result INR 2.1..."<br><br>Interview with the Director of Nursing on February 14, 2012, at 11:10 a.m., in the Nurse's Station, confirmed the facility failed to ensure the laboratory test was done timely.<br><br>Resident #60 was readmitted to the facility on September 26, 2011, with diagnoses including Pneumonia with Aspiration, Alzheimer's Disease, Congestive Heart Failure, Weakness, and GERD (Gastroesophageal Reflux Disease).<br><br>Medical record review of a Physician's Telephone Order dated December 2, 2011, revealed "...recheck PT/INR (measures blood clotting) in 1 week 12-16-11..."<br><br>Medical record review revealed no PT/INR was completed on December 16, 2012.<br><br>Medical record review of the Coumadin Flowsheet dated December 2011, revealed "...12-19-2011...Lab result INR 2.1..."<br><br>Interview with the Director of Nursing on February 14, 2012, at 11:10 a.m., in the Nurse's Station, confirmed the facility failed to ensure the laboratory test was done timely. | {F 502} | | |
| {F 520} SS=E | 483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS<br><br>~~A facility must maintain a quality assessment and~~ assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the | {F 520} | **F520**<br><br>**483.75 (O)(1) QAA Committee-Members/Meet Quarterly/Plans**<br><br>**SS=E**<br><br>**Requirement:** | |



142

PRINTED: 05/14/2012
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 520} | Continued From page 35<br>facility's staff.<br><br>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.<br><br>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.<br><br>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, observation, facility policy review and interview, the facility failed to ensure the Quality Assurance Committee developed and implemented plans to address resident safety related to the use of full side rails likely entrapment and fallsfor three residents (#41, #18, #60) of forty-three residents reviewed. The facility's failure placed resident's #41, #18, and #60, and any resident who used full side rails in Immediate Jeopardy (situation in which a provider's noncompliance with one or more requirements of participation has caused or is likely to cause serious harm, injury, impairment or death).<br><br>The facility provided a Credible Allegation of | {F 520} | A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.<br><br>**Corrective Action Plan:**<br><br>1. A special session of the Quality Assurance QA Committee (Administrator, Director of Nursing, and Assistant Director of Nursing, MDS Coordinator, Maintenance Supervisor, Social Services Director, Activity Director, Food Service Supervisor, Bookkeeper, Therapy Team Leader/Therapy Program Manager, and/or Medical Director) was held on 2/23/12 by the Administrator. The committee reviewed the results of | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 520} | Continued From page 35<br>facility's staff.<br><br>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.<br><br>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.<br><br>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, observation, facility policy review and interview, the facility failed to ensure the Quality Assurance Committee developed and implemented plans to address resident safety related to the use of full side rails likely entrapment and fallsfor three residents (#41, #18, #60) of forty-three residents reviewed. The facility's failure placed resident's #41, #18, and #60, and any resident who used full side rails in Immediate Jeopardy (situation in which a provider's noncompliance with one or more requirements of participation has caused or is likely to cause serious harm, injury, impairment or death).<br><br>The facility provided a Credible Allegation of | {F 520} | the annual survey as expressed during the survey exit with the review of the immediate specifics and implementation of the plan of correction to remove the immediate jeopardy. A Side Rail Policy was developed by the QA Committee and the Medical Director with implementation on 2/28/12 for the assessment of all residents for the use of side rails, the review of MDS's and Care Plans to ensure current interventions and accuracy; the review of Occurrences/Events i.e. Falls (including, but not limited Evaluation for the use of Side Rails, Pre-Restraint, Physical Restraint Assessment, Care Plans, Nurse Event Note Investigation, Nurse Aide Communication Sheet, Root Cause Analysis for appropriate Interventions including the FROG Program, and telephone orders); the monitoring by the Administrative staff to ensure systems are followed and revised as needed; and to ensure staff training is provided as needed for | |



144

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 520} | Continued From page 35<br>facility's staff.<br><br>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.<br><br>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.<br><br>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, observation, facility policy review and interview, the facility failed to ensure the Quality Assurance Committee developed and implemented plans to address resident safety related to the use of full side rails likely entrapment and fallsfor three residents (#41, #18, #60) of forty-three residents reviewed. The facility's failure placed resident's #41, #18, and #60, and any resident who used full side rails in Immediate Jeopardy (situation in which a provider's noncompliance with one or more requirements of participation has caused or is likely to cause serious harm, injury, impairment or death).<br><br>The facility provided a Credible Allegation of | {F 520} | processes/systems implemented. The QA Committee will review audit results related to the annual survey (list not all inclusive: restraints, side rail assessment, side rail measurements, Pre-Restraint Assessment, Physical Restraint Assessment, MDS's, Care Plans, Occurrences) discussing and modifying systems as needed to maintain compliance.<br>2. The Nursing Administration Staff reviewed all residents using side rails, assessing and coding the resident's assessment correctly. Residents using side rails as a restraint were identified and care planned accordingly. A comprehensive assessment was completed; interventions were modified as needed and placed on the individuals care plan. The Administration Team developed a Side Rail Policy with the involvement of the Medical Director with implementation on 2/28/12 to include the utilization of the Evaluation for the use of Side Rail Assessment. | |



145

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 520} | Continued From page 35<br>facility's staff.<br><br>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.<br><br>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.<br><br>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, observation, facility policy review and interview, the facility failed to ensure the Quality Assurance Committee developed and implemented plans to address resident safety related to the use of full side rails likely entrapment and fallsfor three residents (#41, #18, #60) of forty-three residents reviewed. The facility's failure placed resident's #41, #18, and #60, and any resident who used full side rails in Immediate Jeopardy (situation in which a provider's noncompliance with one or more requirements of participation has caused or is likely to cause serious harm, injury, impairment or death).<br><br>The facility provided a Credible Allegation of | {F 520} | 3. The QA Committee received in-service training by the Administrator and the Regional Nurse Consultant on 2/21/12, 2/22/12, and 2/23/12. The in-service covered but was not limited to: facility QA Policies and Procedures; Daily QA morning meetings; Monthly QA (Leadership team, Customer Service, Patient Care and Service); and Quarterly QA (goal setting, brainstorming, root cause analysis, etc.) The QA Committee will address concerns identified during the above meetings as needed, implementing guidelines, modifications with the assistance of the Medical Director to resolve reduce or eliminate concerns identified. The team will review alerts from agencies such as, but not limited to: Center for Medicare Services, Tennessee Health Care Association, and Q-Source to ensure appropriate measures are taken to obtain the goals associated with agency recommendations. Information | |



146

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/14/20
FORM APPROVED
OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 520} | Continued From page 35<br>facility's staff.<br><br>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.<br><br>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.<br><br>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, observation, facility policy review and interview, the facility failed to ensure the Quality Assurance Committee developed and implemented plans to address resident safety related to the use of full side rails likely entrapment and fallsfor three residents (#41, #18, #60) of forty-three residents reviewed. The facility's failure placed resident's #41, #18, and #60, and any resident who used full side rails in Immediate Jeopardy (situation in which a provider's noncompliance with one or more requirements of participation has caused or is likely to cause serious harm, injury, impairment or death).<br><br>The facility provided a Credible Allegation of | {F 520} | discussed in the QA Committee will be disbursed to appropriate department personnel to improve patient care and services by a QA representative through training and educational sessions.<br><br>4. The Administrator or Director of Nursing will review facility audits in morning QA meetings (Monday-Friday) and in the quarterly QA meeting to review areas that have improved and/or may need revisions. Action plans will be developed when a practice is determined to be deficient; the committee will monitor until compliance is met.<br><br>**For Clarification Purposes:** The QA Committee consists of Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, MDS Coordinator(s), Bookkeeper, Food Service Supervisor, Social Worker, Maintenance Director and/or Maintenance Assistant, Activities Director. Direct caregivers (list not | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 520} | Continued From page 35<br>facility's staff.<br><br>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.<br><br>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.<br><br>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, observation, facility policy review and interview, the facility failed to ensure the Quality Assurance Committee developed and implemented plans to address resident safety related to the use of full side rails likely entrapment and fallsfor three residents (#41, #18, #60) of forty-three residents reviewed. The facility's failure placed resident's #41, #18, and #60, and any resident who used full side rails in Immediate Jeopardy (situation in which a provider's noncompliance with one or more requirements of participation has caused or is likely to cause serious harm, injury, impairment or death).<br><br>The facility provided a Credible Allegation of | {F 520} | all inclusive: Licensed Nurses, CNA's, Restorative, Therapy) may be in attendance.<br><br>**Completion Date 3/22/12** | |



148

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 520} | Continued From page 36<br>Compliance on March 5, 2012. A revisit conducted on March 12, 2012, revealed the corrective actions implemented on March 5, 2012, removed the Immediate Jeopardy. Non-compliance for F-221 continues at a "E" level citation (potential for more than minimal harm).<br><br>The findings included:<br><br>Validation of the Credible Allegation of Compliance was accomplished through medical record review, review of facility policy, observation, and interview with the nurses, nursing assistants, and administrative staff. The facility developed a Side Rail Assessment Policy with the involvement of the Medical Director to include the utilization of the evaluation for the use of side rails. The facility provided evidence of side rail assessments for all residents, and removal of side rails when indicated, and evidence bed zone measurements were obtained to reduce or eliminate entrapment risk. The facility provided evidence Fall Risk Assessments, Pre-Restraint Assessments and Physical Restraint Assessments were completed. The facility provided evidence of in-service for all staff and random audits to ensure compliance. The facility conducted a special session of the Quality Assurance committee on February 23, 2012, to review the Side Rail Assessment Policy for the assessment of all residents for the use of side rails, the review of Minimum Data Sets and Care Plans to ensure current interventions and accuracy; the monitoring by the Administrative staff to ensure systems are followed and revised as needed; and to ensure staff training is provided as needed for processes/systems implemented. | {F 520} | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445457 | A. BUILDING _____ B. WING _____ | R 03/12/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TENNESSEE HEALTH CARE | 465 ISBILL RD MADISONVILLE, TN 37354 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 520} | Continued From page 37<br><br>The facility will remain out of compliance at a "E" level until it provides an acceptable plan of correction to include continued monitoring to ensure the deficient practice does not recur and the facility's corrective measure could be reviewed and evaluated by the Quality Assurance Committee. | {F 520} | | |



150